

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>30-4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1304 Medfield Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Agnes</u> Middle <u>Kenny</u> Last <u>Adair</u>						<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>4</u> Year <u>1967</u>											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3/15/1894</u>		<b>9. AGE (In years last birthday)</b> <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Hswf</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Columbus, Ohio</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>Michael Joseph Kenny</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Dukin</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>226-07-2262</u>						<b>17. INFORMANT</b> <u>Hospice records</u> Address _____					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Ca</u> 1992 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Primary Site Not Determined</u> (c) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>0</u> e.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/28/67</u> <b>to</b> <u>8/4/67</u> <b>19</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>8/1/67</u> <b>19</b> , <b>and that death occurred</b> <u>8:15 AM</u> <b>from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Robert J. Mahon</u>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>8/4/67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Robert Mahon, M.D.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>8/7/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>BALTO NATIONAL</u>				<b>23d. LOCATION (City, town or county)</b> <u>BALTO. MD.</u>				<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul E. Charney</u>						<b>ADDRESS</b> _____		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 8 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

MEDICAL CERTIFICATION



*[Faint, mostly illegible text from a document, possibly a letter or report, with some words like "Dear Sir" and "Yours faithfully" visible.]*

RECEIVED  
JAN 21/1919  
JAN 21/1919  
JAN 21/1919

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10534

10534

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Towson</u> c. LENGTH OF STAY IN 1b <u>18 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Treater Baltimore Medical Center</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stansbury Hill Road</u> d. STREET ADDRESS <u>Stansbury Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Edward Andrew Adelsberger</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>August 19 1967</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 9, 1888</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HAIRDRESSER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>BALTIMORE</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BALTIMORE</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>John Adelsberger</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna NASH</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>213-30-1288</u>						<b>17. INFORMANT</b> <u>Pto. clark</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Massive pulmonary edema</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part II of Item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8-19</u> , 19 <u>67</u> , <b>to</b> <u>8-14</u> , 19 <u>67</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>8-19</u> , 19 <u>67</u> , <b>and that death occurred at</b> <u>7:08 PM</u> , <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Jose M. de Leon</u> M.D.												<b>22b. DATE SIGNED</b> <u>8-19-67</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOSE M. DE LEON, M.D.</u>						<b>22d. ADDRESS</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>8/22/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>WM. WATTERS MEM. CEM. COOPERTOWN, MD.</u>				<b>23d. LOCATION</b> (City, town or county) (State)					
<b>24. FUNERAL DIRECTOR</b> <u>Wm. Cook-Brooks Towson</u>						ADDRESS <u>1050 YORK RD. 21204</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 24 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					



x

1904

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10535

10535

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westowne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westowne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>334 Westshire Road</b>		d. STREET ADDRESS <b>334 Westshire Road</b>	
3. NAME OF DECEASED (Type or print) <b>Wayne E. Aldrich</b> First Middle Last		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-27-1898</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heating Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Glen Falls, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herbert Aldrich</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Cashion</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-18-4368A</b>	
17. INFORMANT <b>Mrs. Gertrude I. Aldrich, 334 Westshire Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Generalized CARCINOMATOSIS</b> DUE TO (b) <b>Adenocarcinoma of Lung</b> DUE TO (c) <b>6 mos +</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Peptic ULCER STOMACH</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH</b> , 19 <b>67</b> , to <b>8/24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> , 19 <b>67</b> , and that death occurred at <b>6 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. T. E. Roach</b>		22b. DATE SIGNED <b>8/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. T. E. Roach</b>		22d. ADDRESS <b>5550 Baltimore National Pike</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-28-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore County, Maryland</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue</b>		25a. REC'D BY REGISTRAR <b>21229</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>
DATE <b>AUG 28 1967</b>			



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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10536 CERTIFICATE OF DEATH 10536											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney-Towson Nursing Home, 111 West Rd. Towson, Md. 21204</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Broadview Apts.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Elsie R. Alexander</b>			4. DATE OF DEATH <b>August 13 1967</b>		5. SEX <b>Female</b>						
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Feb. 2, 1884</b>		9. AGE (In years last birthday) <b>83 yrs.</b>			10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Oliver P. Roberts</b>					14. MOTHER'S MAIDEN NAME <b>Ida E. Andrews</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Mrs. Edward Harris</b>		17. INFORMANT <b>Monkton, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1966</b> , to <b>August 1967</b> , that (I) (we) last saw the deceased alive on <b>August 1967</b> , and that death occurred at <b>3:42 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Dr. A. Allan Spier</b>					22b. DATE SIGNED <b>8/13/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Allan Spier</b>				
22d. ADDRESS <b>1501 Pentridge Road</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>8/16/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Pikesville, Balto. Co. Md.</b>				
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>					25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

RECEIVED  
JAN 12 1967

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

DATE: [illegible]

BY: [illegible]

DATE: [illegible]

BY: [illegible]

DATE: [illegible]

BY: [illegible]

DATE: [illegible]

BY: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10537 CERTIFICATE OF DEATH 10537											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>—</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore.</u> 30-4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						d. STREET ADDRESS <u>6030 Alta Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Taylor Allan, Jr.</u>		First Middle Last		4. DATE OF DEATH <u>8 19 1967</u>		Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Can</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-20-07</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>National Claim Ser.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Taylor Allan, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>McCallum, Margaret.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW II 77-10-9872</u>		17. INFORMANT <u>Eileen R. Allan, 6030 Alta Ave.</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - Respiratory failure</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ca of abdominal cavity with involving</u> DUE TO (c) <u>all organ</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>67</u> , and that death occurred at <u>8:25</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Kenny Nardi</u>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>8/19/67</u>	
22c. PHYSICIAN'S NAME (Type) Dr. <u>Navidi</u>						22d. ADDRESS <u>GBMC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial.</u>				23b. DATE THEREOF <u>8/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>			
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, inc. 5305 Harford Rd.</u>						25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Card - Rognator for  
 2 of abdominal cavity with mounting  
 all over

Handwritten notes and stamps at the bottom of the page, including "Kampf", "1941", and "1942".



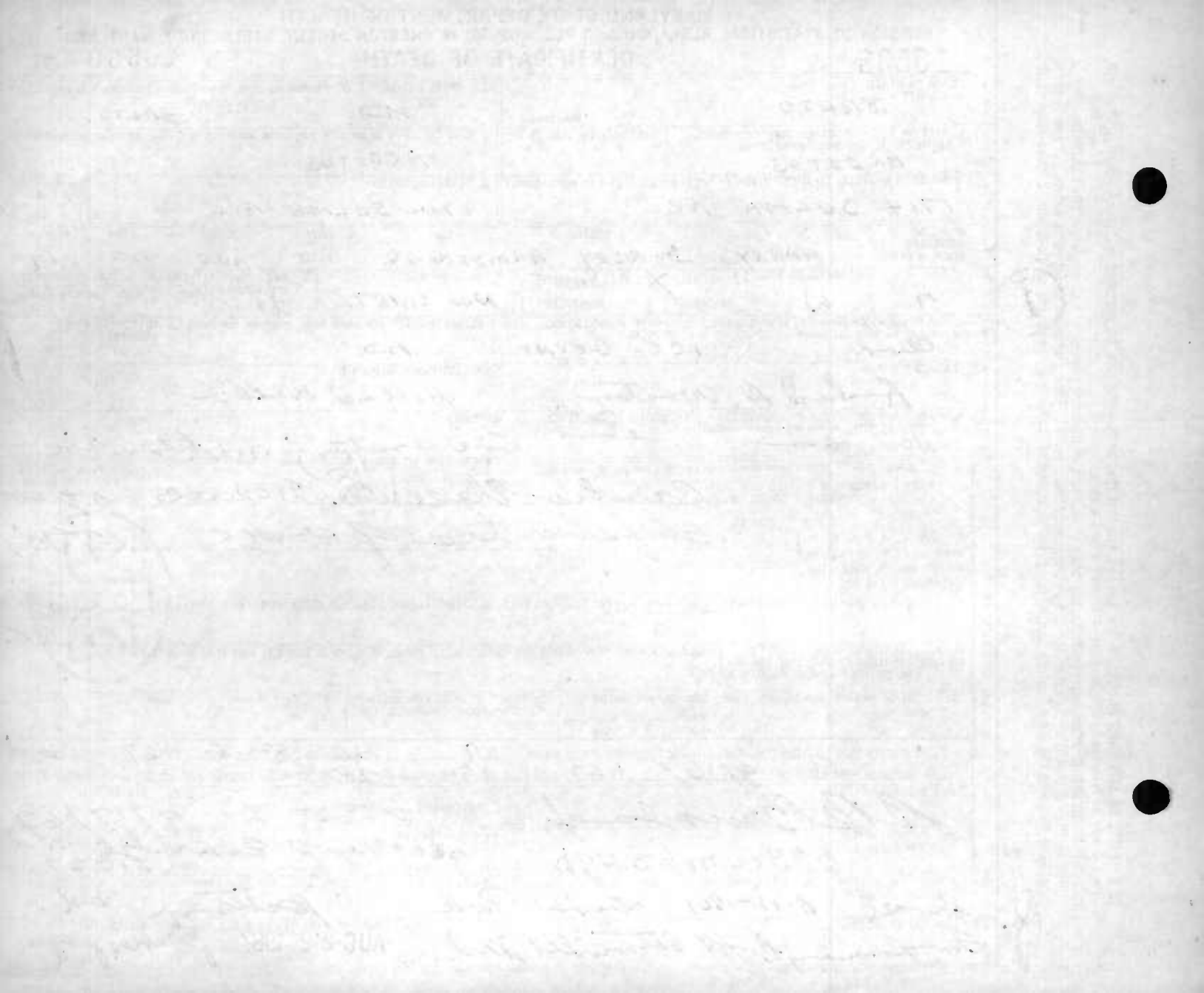
VR A15 (4)  
20M 1/65

**MEDICAL CERTIFICATION**

1

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10538				CERTIFICATE OF DEATH				10538			
1. PLACE OF DEATH a. COUNTY BALTO MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1714 SELMA AVE.						d. STREET ADDRESS 1714 SELMA AVE.				e. IS RESIDENCE ON A FARM? YES NO	
3. NAME OF DECEASED (Type or print) HARRY		First		Middle DORSEY		Last ARMSTRONG		4. DATE OF DEATH AUG. 15		1967	
5. SEX M		6. COLOR OR RACE W		7. MARRIED NEVER MARRIED WIDOWED DIVORCED		8. DATE OF BIRTH Nov 6, 1875		9. AGE (in years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY I.C.C. GOVMT.		11. BIRTHPLACE (County & State, or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard B. Armstrong						14. MOTHER'S MAIDEN NAME Helene Walker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Address Love Armstrong - 1714 Selma Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease 4221 (b) Infirmities of age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 17 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work Not While at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7, 1960, to 8-16, 1967, that (I) (not) last saw the deceased alive on 9/16/ 1967, and that death occurred at 2 PM, from the causes and on the date stated above.											
22a. SIGNATURE BB Brumbaugh M.D.								ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.		22b. DATE SIGNED 8/17/67	
22c. PHYSICIAN'S NAME (Type) BB Brumbaugh								22d. ADDRESS 5609 Main St Elbridge Md 21227			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-18-1967		23c. NAME OF CEMETERY OR CREMATORY London Park				23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Anthony Coronado L JFA Catonsville, Md.								25a. REC'D BY REGISTRAR DATE AUG 22 1967		25b. REGISTRAR'S SIGNATURE James J. Jones	



FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10539

10539

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7122 Heathfield Road</b>				d. STREET ADDRESS <b>7122 Heathfield Road</b>			
3. NAME OF DECEASED (Type or print) First <b>LEMA</b> Middle <b>PEARL</b> Last <b>BAILEY</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 19, 1922</b>		9. AGE (In years lost birthday) yrs. <b>45</b>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>S.F. Bailey</b>			14. MOTHER'S MAIDEN NAME <b>Bama Gardner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>418-22-0863</b>		17. INFORMANT <b>Mr. Warren Bailey Los Angles, Calif.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Contact gunshot wound of chest</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>8-9-</b> p.m. <b>19 67</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles S. Springate</i>			22. DATE SIGNED <b>August 10, 1967</b>				
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>			Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>		23b. DATE THEREOF <b>8-12-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Crest</b>		23d. LOCATION (City or Town) (County) (State) <b>Mobile, Alabama</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>				ADDRESS <b>6500 York Rd.</b>		25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>	
Baltimore, Maryland 21212				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEMORANDUM

FOR THE RECORD

DATE: 10/10/52

TO: Mr. Tolson

FROM: Mr. E. A. Tamm

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>rural, Baltimore</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3817 Patterson Ave</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Baltimore</b> d. STREET ADDRESS <b>3817 Patterson Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Charles Egerton Bald</b> First Middle Last <b>4. DATE OF DEATH</b> <b>Aug 28 1967</b> Month Day Year		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>June 10, 1896</b> Yrs. Months Days Hours Min.	
<b>9a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Marketing clerk</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Standard Oil Co</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Balto. Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Charles Bald</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Isabelle Barnitz</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>WW 1</b> <b>16. SOCIAL SECURITY NO.</b> <b>212-09-0287</b> <b>17. INFORMANT</b> <b>Mrs. Ida M. Bald</b> <b>3817 Patterson Ave</b> <b>Balto. Md.</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>arteriosclerotic heart disease</b> 4 yrs years INTERVAL BETWEEN ONSET AND DEATH: <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>July 1967</b> <b>to</b> <b>Aug 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 1967</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Paul H Royse</b> M.D.		<b>22b. DATE SIGNED</b> <b>Aug 29, 1967</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Paul H Royse</b>		<b>22d. ADDRESS</b> <b>14035oley La. Pikeville Md 21208</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8/31/67</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Woodlawn, Balto Co. Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Foring Byers</b> <b>8728 Liberty Rd</b> <b>Randallstown Md</b>		<b>25a. REC'D BY REGISTRAR</b> <b>AUG 30 1967</b> <b>DATE</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

CERTIFICATE OF BIRTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10541

CERTIFICATE OF DEATH

10541

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>54 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>3409 E. LOMBARD STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLIS J. BEACH</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 30 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 23, 1897</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CORK GRINDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CROWN CORK &amp; SEAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>FAIRFAX COUNTY, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS BEACH</b>		14. MOTHER'S MAIDEN NAME <b>MARY FORBES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW I YES</b>		16. SOCIAL SECURITY NO. <b>212 01 52 39</b>	
17. INFORMANT <b>CLIN. RECORDS VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYELOGENOUS LEUKEMIA, CHRONIC</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 2041		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>7/7/67</b> , 19__, to <b>8/30/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>8/30/67</b> , 19__, and that death occurred at <b>7:25AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles S. Zeiler</i>		22b. DATE SIGNED <b>8/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. 8URIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-2-67.</b>	
23c. NAME OF CEMETERY OR CREMATORIUM <b>Sacred Heart Cemetery</b>		23d. ADDRESS <b>401 German Hill Rd. Ba. Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>		25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			

**Table 1**

CERTIFICATE OF DEATH

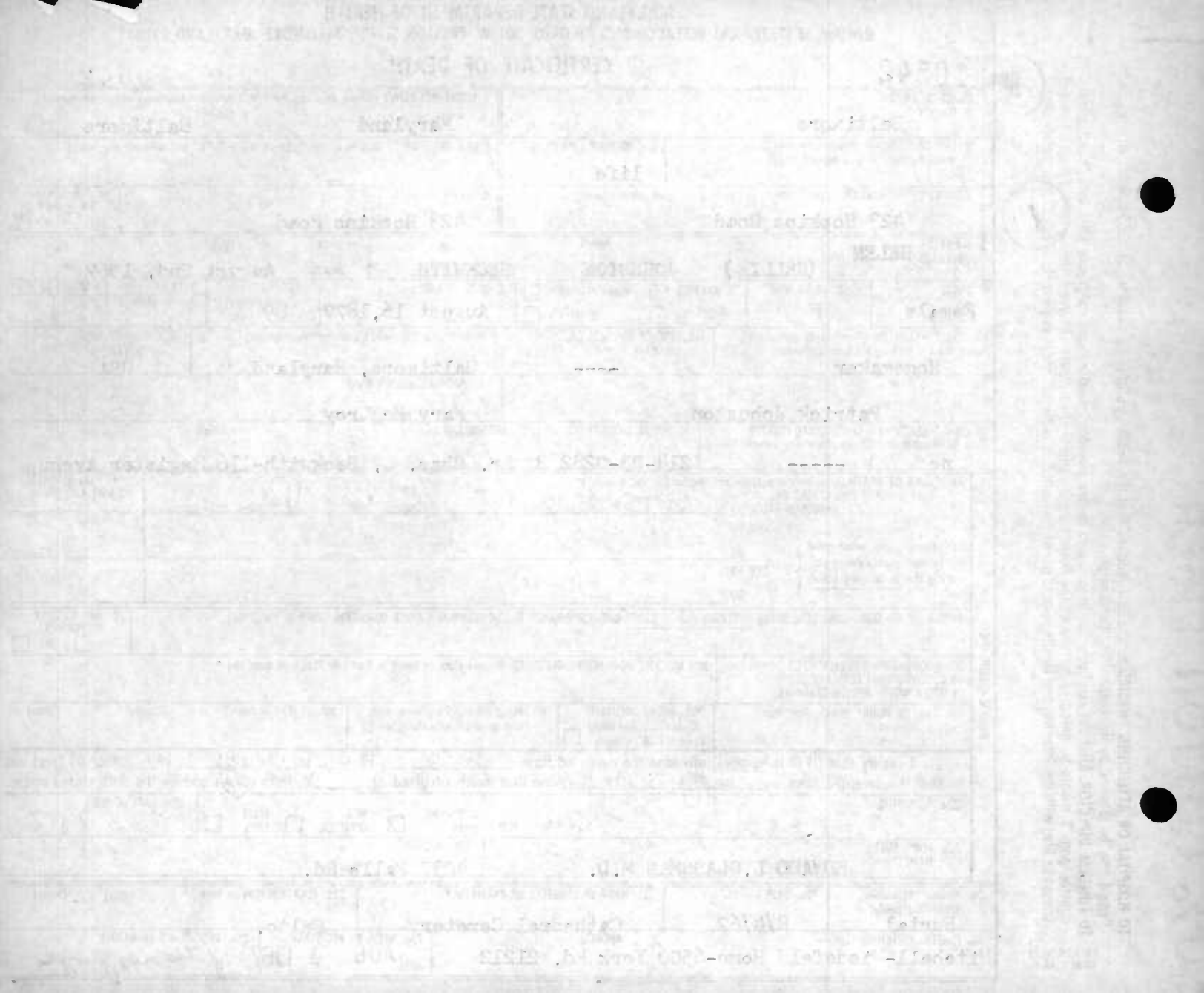
10542

10542

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>423 Hopkins Road</b>		d. STREET ADDRESS <b>423 Hopkins Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED <b>HELEN</b> First Middle Last (Type or print) <b>(NELLIE) JOHNSTON BECKWITH</b>		4. DATE OF DEATH <b>August 2nd, 1967</b> 19 Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 16, 1877</b> 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	9. AGE (In years last birthday) <b>89</b> Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Johnston</b>		14. MOTHER'S MAIDEN NAME <b>Mary McElroy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-03-0282 B</b>	
17. INFORMANT <b>Mr. Chas. L. Beckwith-116 Register Avenue</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>antiseptic C.U. Rx</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 6, 1967</b> to <b>July 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>July 31, 1967</b> , and that death occurred at <b>8</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward L. Glassman</b>		22b. DATE SIGNED <b>8/2/67</b>	22c. PHYSICIAN'S NAME (Type) <b>EDWARD L. GLASSMAN M.D.</b>
22d. ADDRESS <b>4037 Falls Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b>		25. REC'D BY REGISTRAR <b>AUG 4 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

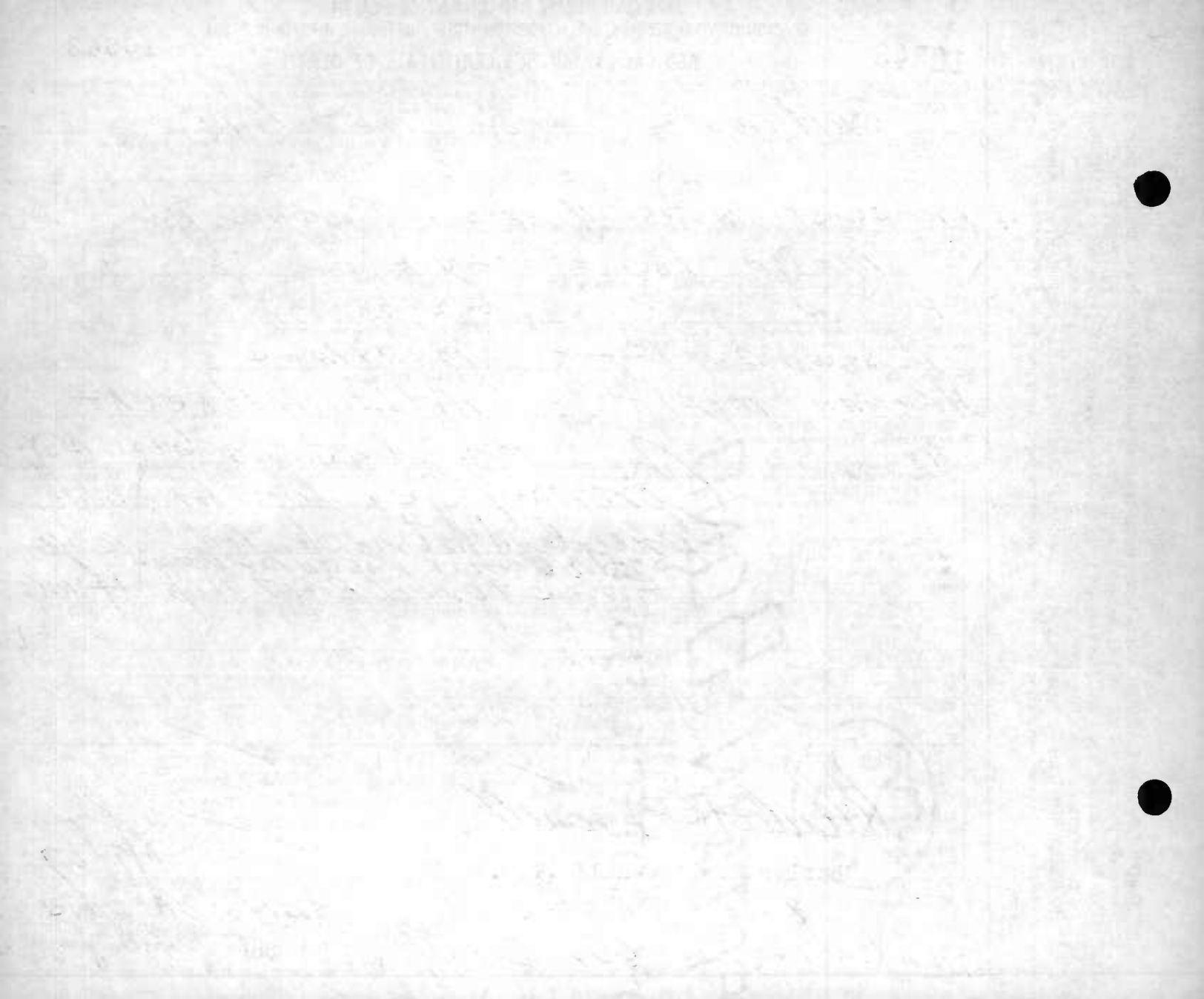
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10543

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ARMACOST NURS. HOME</u>		d. STREET ADDRESS <u>5314 Good Now Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>MAIDA Louise Bender</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-93</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HERMAN MIEKE</u>		14. MOTHER'S MAIDEN NAME <u>HILDA A/Brecht</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. C. Eastwood</u>		Address <u>6101 Moxey</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u> DUE TO <u>Generalized Arteriosclerosis</u> (b) <u>Cardio Renal Vascular Disease</u> DUE TO <u>Fractured Right Hip</u> (c) <u>10 yrs</u> <u>4 links</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22. DATE SIGNED <u>8/9/67</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-12-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO CT. MD.</u>
24. FUNERAL DIRECTOR <u>John C. Miller Inc</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>	
ADDRESS <u>6415 Belair Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>					c. LENGTH OF STAY IN 1b <u>52 days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxlegh Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Bernstein</u> Last <u>Bernstein</u>					4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-1889</u>		9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Springfield, Massachusetts</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Joseph Bernstein</u>					14. MOTHER'S MAIDEN NAME <u>Jennie Friedagot</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-26-3247A</u>		17. INFORMANT Address <u>Mr. Jonas I. Lipman, 3503 Old Court Road #8</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>GIANT Follicle Lymphoma</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>June 4</u> , 19 <u>67</u> , to <u>Aug 11</u> , 19 <u>67</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>August 8</u> 19 <u>67</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard H. Gendason</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>August 11, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>HOWARD H. GENDASON MD.</u>					22d. ADDRESS <u>REISTERSTOWN, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>					25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

2011

X

Great Follicle Symptom

Thyroid gland

Hannah H. Johnson -  
Resident, m.

AUG 18 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10545					10545				
CERTIFICATE OF DEATH					10545				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21218</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>					d. STREET ADDRESS <b>1525 Kingsway Rd.</b>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert William BEST, Sr.</b>					4. DATE OF DEATH Month Day Year <b>August 12, 19 67</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 25, 1898</b>		9. AGE (In years lost birthday) <b>69 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Samuel C. Best</b>					14. MOTHER'S MAIDEN NAME <b>Mary I. Tarleton</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-7982</b>		17. INFORMANT Address <b>Mrs. Mary K. Best (Same)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarction</b> DUE TO <b>Pulmonary-thrombo embolism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>acute pancreatitis</b>					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>July 20, 19 67</b> , to <b>August 12, 19 67</b> that <b>X</b> (we) last saw the deceased alive on <b>August 12, 19 67</b> , and that death occurred at <b>9:15M</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-12-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela Gomez M.D.</b>					22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/16/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEMORANDUM FOR THE ATTORNEY GENERAL

TO : THE ATTORNEY GENERAL  
FROM : THE DEPARTMENT OF JUSTICE  
SUBJECT: [Illegible]  
[Illegible text follows, appearing to be a memorandum format with various lines of text and possibly a signature block.]

[Illegible text continues, appearing to be the main body of the memorandum, possibly containing a list or detailed report.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE  
HEALTH DEPT.

VR A15ME (5)  
6M 1/67

10546				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				10546					
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY		Baltimore Co.		o. STATE		Maryland 21212		b. COUNTY		Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Towson		c. LENGTH OF STAY IN 1b		Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
St. Joseph Hospital				6004 Clearspring Road									
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH									
Robert Henry Bieneman				August 13, 1967									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		10. UNDER 1 YEAR 11. UNDER 24 HRS.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 29, 1951		16		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
Student				---				Baltimore, Md.				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
Robert C. Bieneman				Joan Velenovsky									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address					
No ---				218-52-4966				Robert C. Bieneman (Father) Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Drowning</u>													
DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
				Found Submerged in Pool of Water									
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
12:51 p.m. August 4, 1967				While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Swimming Pool					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
22. DATE SIGNED				8/13/67									
ACTUAL SIGNATURE				Charles F. O'Donnell, M.D.									
EXAMINER'S NAME (Type)				Charles F. O'Donnell, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY					
Burial				Aug. 17, 1967				Baltimore National Cemetery Balto. Md.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR					
Seitz Funeral Home				5209 York Road				25b. REGISTRAR'S SIGNATURE					
Eugenia K. Seitz				Balto. Md. 21212				DATE AUG 15 1967					

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10547

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b> c. LENGTH OF STAY IN lb <b>103</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kingsville</b>		d. STREET ADDRESS <b>Box 270, Route 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN J. BLISSEL</b>		4. DATE OF DEATH Month Day Year <b>August 14, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-11-1902</b> 9. AGE (In years lost birthday) yrs. <b>64</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Army Chemical Center</b>	
11. BIRTHPLACE (State or foreign country) <b>New Kensington Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John J. Blissel</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Splean</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walker Funeral Home New Kensington Pa.</b>		Address <b>15068</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>8/15/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-17-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>WestMoreland Co. Penna.</b>
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 7401 Belair Rd</b>		25a. REC'D BY REGISTRAR <b>(36)</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

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*[Handwritten signature]*  
[Illegible text]

[Illegible text]

[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10548 Item #8 Film #G397 4/10/67 pp  
CERTIFICATE OF DEATH 10548

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>CATONSVILLE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co.</u> c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>13A/140</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Co.</u> d. STREET ADDRESS <u>1107 McAdoo Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Beatrice Maria Beck</u> First Middle Last 4. DATE OF DEATH <u>Aug 12, 1967</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1871</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>96</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ziegler, FRED</u>		14. MOTHER'S MAIDEN NAME <u>CLARA HAYES</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-52-2154</u>		17. INFORMANT <u>1107 McADOO AVE BALTO-7 MD.</u> <u>MRS. ALICE GALGANO</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> <u>332X</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>40 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>67</u> to <u>8/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>67</u> , and that death occurred at <u>12:45</u> PM, from the causes and on the date stated above.						
22a. SIGNATURE <u>DR. DAVID E. ZICKAFOOSE</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/12/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>DR. DAVID E. ZICKAFOOSE</u>		22d. ADDRESS <u>4 VFW Lane, Ellicott City, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)
<u>REMOVAL-BURIAL AUG. 15, 1967 GREEN HILL</u>				<u>WAYNESBORO, PENNA</u>		
24. FUNERAL DIRECTOR <u>Easton Funeral Home Catonsville, Md.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10549

CERTIFICATE OF DEATH

10549

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. LENGTH OF STAY IN lb <b>Lansdowne</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>246 Second Avenue</b>		d. STREET ADDRESS <b>246 Second Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Agnes H. Bopst</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-10-1905</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frank B. Ober</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hobson</b>		14. MOTHER'S MAIDEN NAME <b>Maude Gutermuth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-6552</b>	
17. INFORMANT <b>Mr. Guy E. Bopst, 246 Second Avenue 21227</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> <b>Coronary occlusion</b> DUE TO (b) <b>arterio-sclerotic heart disease</b> DUE TO (c) <b>many years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>p.m.</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-4-</b> 19 <b>67</b> to <b>8-30-</b> 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8-30-</b> 19 <b>67</b> , and that death occurred at <b>10:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Florian P. Nadolski</b>		22b. DATE SIGNED <b>9-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Florian P. Nadolski</b>		22d. ADDRESS <b>2619 Hammonds Ferry Road, Balto., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-2-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Howard County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

1943

STATEMENT OF DEATH

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CERTIFICATE OF DEATH

10550

10550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>57 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>5606 WESLEY AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAYFIELD</b> Middle <b>--</b> Last <b>BOYD</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>8</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>8/1/17</b>		9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (County & State, or foreign country) <b>YORK COUNTY, SOUTH CAROLINA U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CLOVIN BOYD</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE JAMISON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>248 42 27 46</b>		17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) <b>PEPTIC ULCER, GASTRIC</b>						INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>POST OPERATIVE STATE CERVICAL LAMINECTOMY, RECENT</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If this hospital) attended the deceased from <b>6/12/67</b> , 19__ to <b>8/8/67</b> , 19__, that (If we) last saw the deceased alive on <b>8/8/67</b> , 19__, and that death occurred at <b>1:00 P.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Ivan L. Butler</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>IVAN L. BUTLER, M. D.</b>				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem. Balto. Md.</b>		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <i>Charles H. Powell</i>		25a. REC'D BY REGISTRAR <b>WILLIAMS FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		DATE <b>AUG 14 1967</b>	

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ESTIMATE OF COST

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10551

CERTIFICATE OF DEATH

10551

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN lb <b>5 DAYS</b>		d. STREET ADDRESS <b>803 E. 22nd Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PRESLEY</b>		4. DATE OF DEATH Month <b>8</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/98</b>
9. AGE (In years last birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER STEEL COMPANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BRUNSWICK, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>PETERSON BOYD</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA (last name unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213 07 31 89</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH. FORT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ABDOMINAL CARCINOMATOSIS UNKNOWN PRIMARY SITE</b> DUE TO <b>UNDETERMINED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PERITONITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 27</b> , 19 <b>67</b> , to <b>AUGUST 1</b> , 1967, that (I) (we) last saw the deceased alive on <b>AUGUST 1</b> , 19 <b>67</b> , and that death occurred <b>10:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>J. D. Talbert</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Aug 4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>ELLIOTT FUNERAL HOME CAROLINE AND BIDDLE STS</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1967</b>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

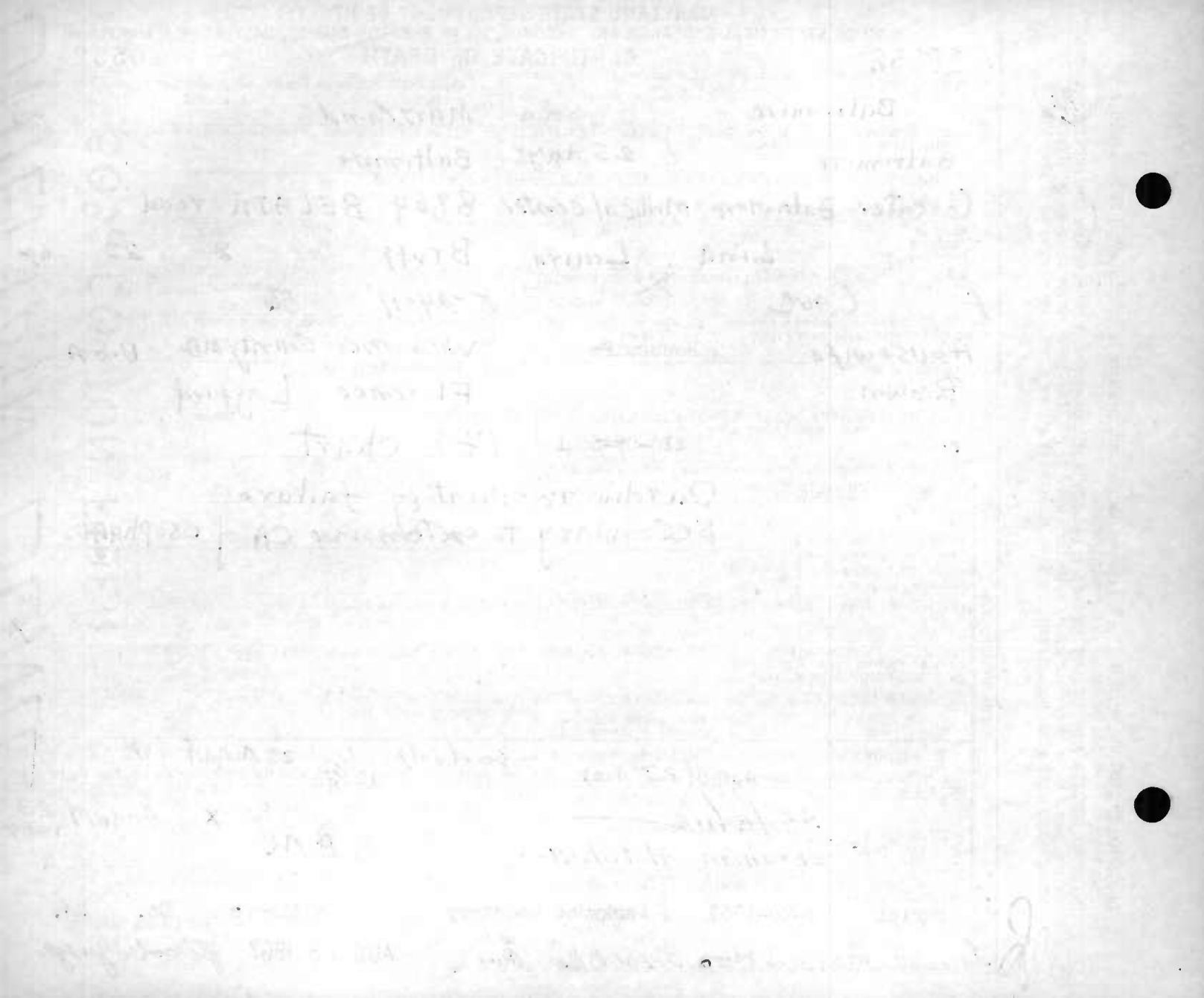
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10552						10552							
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>8864 BELAIR road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Lina</u> Middle <u>Laura</u> Last <u>Bruff</u>			4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1967</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>CAUC</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>5-29-11</u>			9. AGE (In years last birthday) <u>56</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				
13. FATHER'S NAME <u>Brown</u>						14. MOTHER'S MAIDEN NAME <u>Florence Layfield</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-09-8841</u>			17. INFORMANT <u>Pt's chart</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Secondary to extensive CA of esophagus</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>30 of July, 1967</u> to <u>23 August, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 23, 1967</u> , and that death occurred at <u>12:58 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Ebrahim Abtahian</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>August 23, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>Ebrahim Abtahian</u>						22d. ADDRESS <u>G B M C</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8-26-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>					
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 2401 Belair Road</u>						25a. REC'D BY REGISTRAR <u>36</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10553						10553					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			BALTIMORE			e. STATE			b. COUNTY		
CATONSVILLE			MARYLAND			MARYLAND			BALTO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
CATONSVILLE			1 year 4 mos			BALTIMORE			03-1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM		
SUMMIT NURSING HOME						1423 REGISTER AVE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM		
(Type or print)			First Middle Last			Month Day Year			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
HILDA A. BUSHOUT						August 20 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
F		W		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3/5/94		73 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				Own Home		Jersey City N. J.				U.S.A	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
REINHOLD STEBE MAN						Louise DISQUE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
No				083-20-6557		CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME											
4201 DUE TO											
Conditions, if any, which gave rise to immediate cause (b) CORONARY INSUFFICIENCY											
(a), stating the underlying cause last. (c) ASCVD.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from July 3, 1967 to Aug 20, 1967 that (I) (we) last saw the deceased alive on 8/18, 1967, and that death occurred 8:11 PM, from the causes and on the date stated above.											
22a. SIGNATURE E. KASATIY, M.D. M.D.											
22b. DATE SIGNED 8/20/67											
22c. PHYSICIAN'S NAME (Type) E. KASATIY, M.D.											
22d. ADDRESS 1801 FREDERICK RD, BALTIMORE, MD 21228											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
Burial											
23b. DATE THEREOF 8-23-1967											
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park Balto. County, Md.											
23d. LOCATION (City, town or county) (State)											
23e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge											
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., Md. 21212											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
10554									
CERTIFICATE OF DEATH									
10554									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ivy Hall Nursing Home</b>					d. STREET ADDRESS <b>6506 Cleveland Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA D. BUHNER</b>					4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 28, 1871</b>		9. AGE (In years last birthday) yrs. <b>95</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Selig</b>					14. MOTHER'S MAIDEN NAME <b>Mary Fladung</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Theresa A. Gunkel 6506 Cleveland Ave.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> DUE TO <b>acute heart failure</b> (b) <b>Arteriosclerosis</b> DUE TO <b>10yr.</b> (c)									INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> , 19 <b>53</b> to <b>8/24/</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>8/11/81</b> , 19 <b>67</b> , and that death occurred at <b>2:11</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>David H. Andrew</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>8/25/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David H. Andrew</b>					22d. ADDRESS <b>6905 Dunmanway.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 26, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colgate, Md.</b>		
24. FUNERAL DIRECTOR <b>Ulrich Funeral Home Dundalk, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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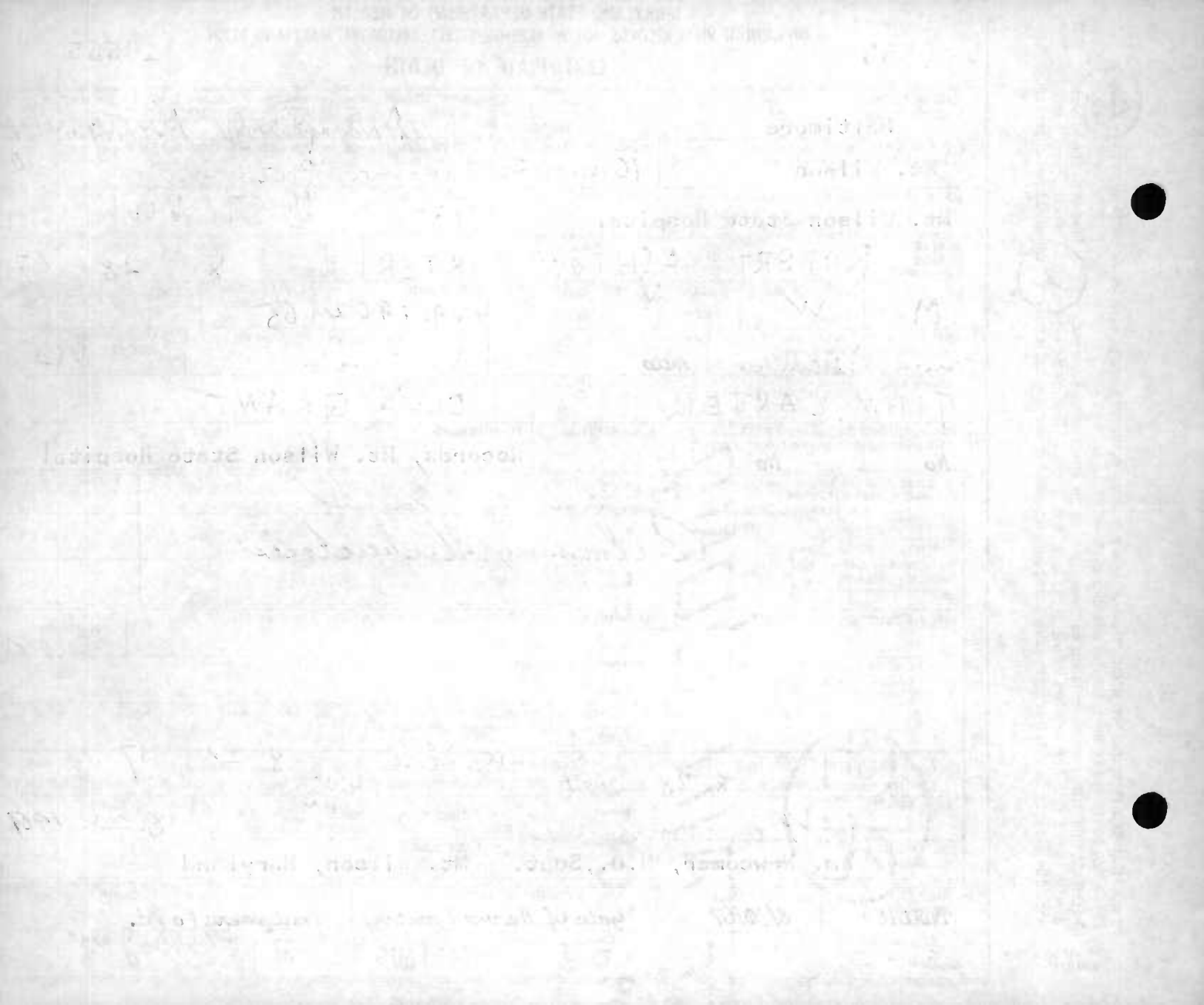
VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Montgomery</b> DISTRICT OF COLUMBIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>	c. LENGTH OF STAY IN TOWN <b>10 months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park - DC</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>7339 8th Str. N.W.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ROBERT ASHTON CARTER</b>		4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.9.1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	9. AGE (In years last birthday) yrs. <b>65</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN CARTER</b>		14. MOTHER'S M maiden name <b>ELLA GRANT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Lungs</b> DUE TO (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10.26.66</b> , 19 <b>66</b> , to <b>8.28</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8.28</b> 19 <b>67</b> , and that death occurred at <b>4:05M</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED <b>8.28.1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Montgomery Co Md.</b>
24. FUNERAL DIRECTOR <b>J. J. Hunterman &amp; Son</b>		25a. REC'D BY REGISTRAR <b>5732 Gauley</b>	
		25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>	

AUG 31 1967





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10556

10556

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>Baltimore 21234</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>8712 Roper Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Steven James CARTER</b>				4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 9, 1967</b>	
9. AGE (In years last birthday) <b>7</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Ballard Carter</b>				14. MOTHER'S MAIDEN NAME <b>Jean Diane Gorleski</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden cardiorespiratory failure</b> DUE TO (b) <b>Unknown cause</b> DUE TO (c) <b>Unknown cause</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> Month <b>19</b> Day <b>19</b> Year <b>1967</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that <b>20</b> (this hospital) attended the deceased from <b>8/9/</b> , 19 <b>67</b> , to <b>8/12/</b> , 19 <b>67</b> , that <b>20</b> (we) last saw the deceased alive on <b>8/12/</b> , 19 <b>67</b> , and that death occurred at <b>4:45 M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez M.D.</b>				22b. DATE SIGNED <b>August 12, 1967</b>		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>				25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR A15 (4)  
25M 1/67

1-248876

STATE OF TEXAS

County of \_\_\_\_\_

Page \_\_\_\_\_

Page \_\_\_\_\_

Know all men that \_\_\_\_\_

do hereby certify that \_\_\_\_\_

is the true and correct \_\_\_\_\_

of the \_\_\_\_\_

and \_\_\_\_\_

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FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div> <div>1</div> <div> <div>FOR STATE HEALTH DEPT.</div> <div>M</div> </div> </div> <div> <div>TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.</div> <div>TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.</div> </div> <div> <div>10557</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10557</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bacon Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> d. STREET ADDRESS <u>Bacon Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Iven Ella Case</u>				4. DATE OF DEATH <u>12/7/1967</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u>				9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
13. FATHER'S NAME <u>Howard Jackson Case</u>				14. MOTHER'S MARRIAGE NAME <u>Margaret Stevenson</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213385584</u>				17. INFORMANT <u>Howard M. Case, Middletown Del.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart change from life caused secondary</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>to Adeno Carcinoma of Tongue</u> DUE TO (c) <u>1419</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15 Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>G. M. Francis</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <u>8/11/67</u>			
EXAMINER'S NAME (Type) <u>A-M. FRANCIS</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) <u>PARKTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>8/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angelica Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Angelica, NY</u>			
24. FUNERAL DIRECTOR <u>Daniel S. Hartman, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>AUG 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10558

10558

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN Tb <u>2 MONTHS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL</u>		d. STREET ADDRESS <u>1204 OVER BROOK RD.</u>	
3. NAME OF DECEASED (Type or print) <u>RUSSELL WALTER CHALK</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-15</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ACME SUPER MKT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EMORY ELMER CHALK</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET KNISLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-7099</u>	
17. INFORMANT <u>Admission Sheet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <u>CP of lungs</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-30-67</u> , 19 <u>67</u> , to <u>8-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-31</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Rah Bassiri</u>		22b. DATE SIGNED <u>8-31</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rahim Bassiri</u>		22d. ADDRESS <u>GREATER BALTO MEDICAL CENTER</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	23d. LOCATION (City or Town) (County) (State) <u>Old Frederick Rd, Md</u>
24. FUNERAL DIRECTOR <u>Austin E. Donovan - 3818 Poland Ave</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	

220-02-01 Admission Sheet

Emory Elmer Chalk

Margaret Knisley

General Baker Super Mk. Baltimore Md.

Mare White 4-14-12 22

Russell Walter Chalk

Glenn E. B. - 1204 Over Brook Rd

James 2 minutes Baltimore

Carl B. B.

Margaret

Supp 1/07 - New Canaan

Old Frederick Rd, Md

220-02-01



10559

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>Baltimore 21234</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b> d. STREET ADDRESS <b>9221 Harford View Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John J. CHLUDZINSKI</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 August 1921</b> 9. AGE (In years last birthday) <b>45</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stainless Steel Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Chludzinski</b>		14. MOTHER'S MAIDEN NAME <b>Maryanna Borkowski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW2--Korean</b>		16. SOCIAL SECURITY NO. <b>125-01-4072</b>	
17. INFORMANT <b>Mrs. Josephine F. Chludzinski</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>JO</b> (this hospital) attended the deceased from <b>July 17, 1967</b> , to <b>August 22, 1967</b> , that <b>JO</b> (we) lost saw the deceased alive on <b>August 22, 1967</b> , and that death occurred at <b>2:35 M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Beatriz P. Dizon</i>		22b. DATE SIGNED <b>August 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Beatriz P. Dizon, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/26/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 23 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

131111

815018

32. 2011-12-12

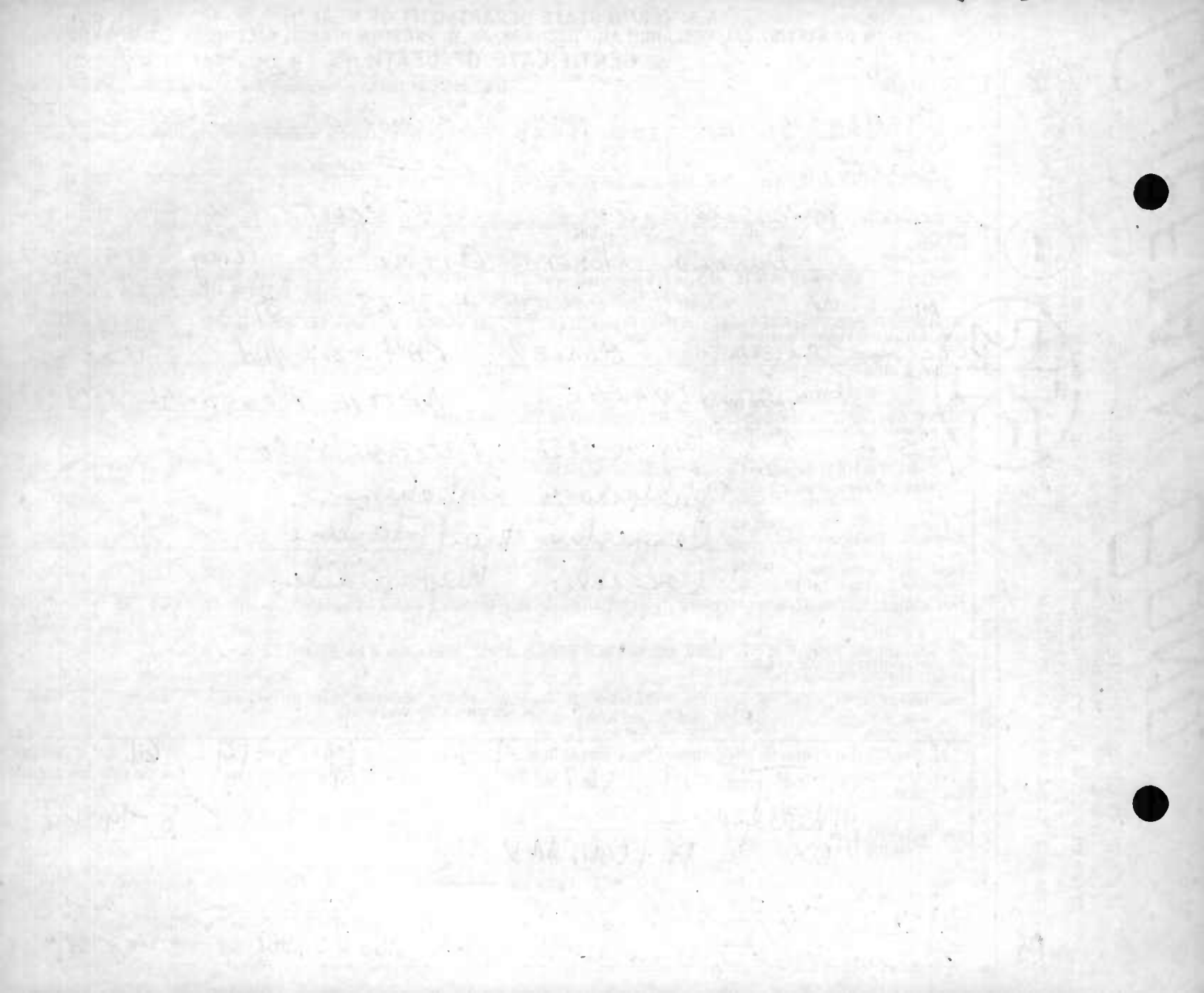
64. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

LEONARD J. BIRCH, INC., BALTO., MD. 21211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10560 RA 13263701 T47 P											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt. City</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				30-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gruber-Balt. Medical Center</u>						d. STREET ADDRESS <u>3247 Chestnut Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>JOSEPH</u> Last <u>CITRO</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1967</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-28</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTE HOME SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>UNKNOWN EUGENE</u>						14. MOTHER'S MAIDEN NAME <u>NETTIE ROSSO-ALFINITO</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>216-20-9037</u>		17. INFORMANT <u>PATIENT'S CHART</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 431X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> (c) <u>Coxsackie Myocarditis</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>67</u> , and that death occurred at <u>3:25</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph M. DeLeon</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>8-19-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Aug 23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>			
24. FUNERAL DIRECTOR <u>Frank J. Leitz</u>						ADDRESS <u>814 W 36 St Baltimore</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE		
						DATE <u>AUG 22 1967</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~send~~ give carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

10561		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		10561	
1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>25 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO. #21224,</b>		<b>30.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTO. Medical Cntr.</b>				d. STREET ADDRESS <b>3314 Fleet Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joshua Green Coker</b>				4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-8-05</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Millwright</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joshua Green Coker</b>		14. MOTHER'S MAIDEN NAME <b>MARY V. GREEN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>17-25-7816</b>		17. INFORMANT <b>HOSPITAL CHART</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of BRONCHUS</b> DUE TO <b>1621</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with METASTASIS to BONE.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>I</b> (this hospital) attended the deceased from <b>8/5</b> , 19 <b>67</b> , to <b>8/30</b> , 19 <b>67</b> that <b>1/2</b> (we) lost saw the deceased alive on <b>30 day Aug 19 67</b> , and that death occurred at <b>7:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Duncan McElie</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DUNCAN MCBIE MCBIE</b>				22d. ADDRESS <b>Greater Baltimore Medical Centre</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-2-67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>7401 GERMAN HILL RD, BA. CO., MD.</b>	
24. FUNERAL DIRECTOR <b>Charles S. Zeiler</b>				ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>		25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

BALTO.

MD.

2200 BALTO.

GREATER BALTO. Medical Center 331 First Street

JOHN GREEN COKE

6-8-02

HALE CAN

Millwright

JOHN GREEN COKE

UNKNOWN HOSPITAL CHART

CARCINOMA of BRONCHUS

with METASTASIS to BONE

JOHN GREEN COKE  
BALTO. MEDICAL CENTER

JOHN GREEN COKE  
BALTO. MEDICAL CENTER

8/2

8/20

8/20

8/20



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Five Farms (Balto. Country Club)</b>		d. STREET ADDRESS <b>221 Ridgemedo Road</b>	
3. NAME OF DECEASED (Type or print) <b>John Henry Collison, Jr.</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/1897</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Agent Conn. Mutual-Ins.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Collison, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Houck</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>217-22-7811</b>	
17. INFORMANT <b>Mrs. Doll T. Collison</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>3 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1961</b> to <b>July 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 27, 1967</b> , and that death occurred at <b>1:52 P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Dr. K. A. Peter van Berkun</b>		22b. DATE SIGNED <b>8/4/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. K. A. Peter van Berkun</b>		22d. ADDRESS <b>100 W. University Pkwy.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/7/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Balto. Co. Md</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. DATE <b>AUG 7 1967</b>	
ADDRESS <b>4905 York Road Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

10082

EXHIBIT OF DEAN

Exhibit

Five copies (one, County Clerk)

221 - 1000000000

John - Jenny

Collins, Jr., August 3, 1900

1000000000

John - Jenny

Collins, Jr., August 3, 1900

John - Jenny

Yes 221-1000000000

John - Jenny

Collins, Jr., August 3, 1900

1000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10563 CERTIFICATE OF DEATH 10563			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>19 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie, Maryland</b>	
f. STREET ADDRESS <b>8800 Maple Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Wade</b> Middle <b>H.</b> Last <b>Colson</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1880</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>67</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Foreman</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Richard Colson</b>		14. MOTHER'S MAIDEN NAME <b>Martha Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction,</b> <b>4201</b> DUE TO <b>old diaphragmatic Myocardial Infarction</b> (b) <b>Arteriosclerotic cardiovascular Ht. Dis. &amp; 20 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis, Generalized, Senile</b> <b>20 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pneumonia, Left Lower Lobe, treated, improved, org. undet.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1967</b> to <b>Aug. 7, 1967</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>Aug. 7, 1967</b> , and that death occurred at <b>12:50 a.m.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

10564

10564

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>30.4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3324 Foster Avenue #21224</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Magdalene Cooper</b>		4. DATE OF DEATH Month Day Year <b>August 21 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1900</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Hosza</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Steiner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-34-7962</b>	
17. INFORMANT <b>Margaret E. Wilson : 706 S. Conkling St. Balto., 21224, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetes Mellitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Cerebral Thrombosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 15</b> , 1967, to <b>August 21</b> , 1967, that (I) (we) last saw the deceased alive on <b>August 21</b> 1967, and that death occurred at <b>4:50AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>V. Phupakdi</b>		22b. DATE SIGNED <b>August 21, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Vichian Phupakdi, M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-24-67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>7225 Eastern Blvd. Ba. Co., Md.</b>
24. FUNERAL DIRECTOR <b>Charles S. Jule</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jule</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1000

STATE OF TEXAS

County of ...

Know all men by these presents, that ...

... of the County of ...

... do hereby certify that ...

... at the City of ...

... and ...

Witness my hand and seal of office this ... day of ... 19...  
Notary Public for the State of Texas

...

...



X

...

...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10565		10565	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN 1b <b>31yr2mth16dys</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>205 North High Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>John</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1899</b>
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		13. FATHER'S NAME <b>Anthony Coppolina</b>	
14. MOTHER'S MAIDEN NAME <b>Fortunata Peppitone</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>220-56-7815</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>June 14, 1936</b> to <b>Aug. 30, 1967</b> , that (we) last saw the deceased alive on <b>Aug. 30, 1967</b> , and that death occurred at <b>11:30 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		22b. DATE SIGNED <b>8-30-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept 1 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) (County) (State) <b>Old Federal Rd Baltimore</b>
24. FUNERAL DIRECTOR <b>Private Funeral Home 1216 S Chasest St</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10566

CERTIFICATE OF DEATH

10566

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>1 hour</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med Ctr.</u>		d. STREET ADDRESS <u>Rt. #1 Box 7</u>	
3. NAME OF DECEASED (Type or print) <u>Anita Elizabeth Cornthwaite</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co. Md.</u>
13. FATHER'S NAME <u>Calvin Whiteford</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-8450</u>	
17. INFORMANT <u>Patients chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Myocardial Infarction</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-11-1967</u> , to <u>8-11-1967</u> , that (I) (we) last saw the deceased alive on <u>8-11-1967</u> , and that death occurred at <u>1:16 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jose M. de Leon</u> M.D.		22b. DATE SIGNED <u>8-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>August 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FRIENDS BURIAL GROUNDS</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>1050 York Rd Towson, Md. 21204</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DEPARTMENT OF AGRICULTURE

WASHINGTON

DEPARTMENT OF AGRICULTURE

June 1, 1901

June 1, 1901

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,

John D. Hays

Secretary of Agriculture

Washington, D. C.

Very truly yours,

John D. Hays

Secretary of Agriculture

Washington, D. C.

Very truly yours,

John D. Hays

Secretary of Agriculture

Washington, D. C.

Very truly yours,

John D. Hays

Secretary of Agriculture

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

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<div> <div>10567</div> <div>10567</div> </div> <div> <div>10567</div> <div>10567</div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b></b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plant Dispensary</b>						d. STREET ADDRESS <b>3820 Elmley Avenue #13</b>					
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Joseph</b> Last <b>COSGROVE Jr.</b>						4. DATE OF DEATH Month <b>Aug</b> Day <b>15</b> Year <b>67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-10-17</b>		9. AGE (In years last birthday) <b>50 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Making</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Martin J. Cosgrove Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Mary Stanford</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>216-10-9041</b>		17. INFORMANT Address <b>Mary Cosgrove, wife, above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A.S.C.V. Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b></b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>X</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>E</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>M. B. Davis</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <b>8-15-67</b>			
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>				6800 Morningside Rd. Dundalk, Md. 21222							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane #13</b>						25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>					
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

3850 Maple Avenue

London

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10568

## CERTIFICATE OF DEATH

10568

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 Gwynn Lake Dr</u>		d. STREET ADDRESS <u>17 Gwynn Lake Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H.</u> Last <u>Council</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11, 1899</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE, MD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>USA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Wm B. Council</u>		14. MOTHER'S MAIDEN NAME <u>Roe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWI-Navy</u>		16. SOCIAL SECURITY NO. <u>218-32-3356</u>	
17. INFORMANT <u>Ruth S. Council</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> DUE TO <u>4200</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent Carcinoma of Larynx</u> (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug - 13, 1966</u> , to <u>Aug 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 22, 1967</u> , and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Earl L. Chambers</u>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		22d. ADDRESS <u>4108 Liberty Hts Balto. Md</u>	
23a. BURIAL, CREMATION, REMEM. VAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LODOW PARK CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Form with multiple sections and fields, including a large table area. The text is faint and mostly illegible. The form appears to be a standard administrative or reporting document.

Vertical text on the right margin, possibly a date or reference number, oriented vertically.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10569

## CERTIFICATE OF DEATH

10569

Item #2a, c & d Film #391 8/13/67

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Hampshire</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forleigh Nursing Home</u>		d. STREET ADDRESS <u>402 Laurel St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>Creamer</u> Last <u>Creamer</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone - Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Creamer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Frances Hightaffei</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (U) this hospital attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>8-10</u> , 19 <u>67</u> , that (U) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>67</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>David I. Miller</u>		22b. DATE SIGNED <u>8-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>		22d. ADDRESS <u>Loudon Rd. - Owings Mills, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>8/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>William J. Tiekner &amp; Sons North &amp; Emma</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10570					10570				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			c. LENGTH OF STAY IN 1b <b>20 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6800 Mornington Road</b>					d. STREET ADDRESS <b>7009 Railway Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>G.</b> Last <b>Critzman</b>			4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1967</b>						
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27-1904</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weigher</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>American Smelting &amp;</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William G. Critzman</b>				14. MOTHER'S MAIDEN NAME <b>Anna Greenwauld</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>212-10-1536</b>		17. INFORMANT <b>Sister, Mrs. Edna Schoepflin, #2, a, b, c, d.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> 4200 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2-3 YRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 27, 1967</b> to <b>AUG 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>AUG 3 1967</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>M B Davis</b>					22b. DATE SIGNED <b>August-5-1967</b>			22c. PHYSICIAN'S NAME (Type) <b>Melvin B. Davis M.D.</b>	
22d. ADDRESS <b>6800 Mornington Rd. Dundalk, Md. 21222</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>August-7-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland 21224</b>		
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>					25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE DATE <b>AUG 7 1967</b> <b>J Charles Judge</b>				

SECRETARY OF STATE  
WASHINGTON, D. C.

Baltimore  
Maryland

50 years  
Baltimore

400 Lexington Road  
A.C. Bellamy Avenue

John  
Baltimore

John  
Baltimore

Baltimore  
Maryland

Baltimore Co.

John G. Bellamy

500-1000  
Baltimore, Md.

John G. Bellamy

August-1907

John G. Bellamy

John G. Bellamy

John G. Bellamy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

10571  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10571

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL BALTIMORE</u> c. LENGTH OF STAY IN 1b <u>11 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9702 OAKDALE AVE</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL BALTIMORE 21234</u> d. STREET ADDRESS <u>9702 OAKDALE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRED</u> <u>DEFOREST</u> <u>CROSBY</u>		4. DATE OF DEATH Month Day Year <u>AUGUST</u> <u>27</u> <u>1967</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 19, 1902</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMISSIONER AMATEUR SPORTS. BALTO. CITY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EDUCATION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>ONTARIO NEW YORK</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>WILLIAM CROSBY</u> <u>1887-1946</u>				
14. MOTHER'S MAIDEN NAME <u>ALICE GEORGE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				
16. SOCIAL SECURITY NO. <u>1943-1946</u>			17. INFORMANT Address <u>WIFE 9702 OAKDALE AVE</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SMALL CELL CARCINOMA OF LUNG.</u> 163X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , to <u>AUG 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUG 22, 1967</u> , and that death occurred at <u>3:04</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel I O'Mansky</u>				22b. DATE SIGNED <u>Aug 27 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL I O'MANSKY</u>				22d. ADDRESS <u>PS 23 York River Blvd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/1/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resthaven Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Phelps, New York.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Insurance Co. of N.Y. & N.J., Inc., 110 Nassau St., N.Y.C.

Reston Cemetery

Philips, New York

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10572

10572

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>30.4</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS <b>1228 N. 62nd St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EVELYN IDA CROUSE</b>		4. DATE OF DEATH Month Day Year <b>August 15, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-15-25</b>
9. AGE (In years lost birthday) yrs. <b>42</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wife Assembler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Litz</b>		14. MOTHER'S MAIDEN NAME <b>Wynona Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219 22 5350</b>	
17. INFORMANT <b>Charles M. Litz</b>		Address <b>400 Henry St. Joppa, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism complicating Multiple</b> <b>8254 XXXXX Injuries</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subj. in auto accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>UNK p.m. 8/6 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>
20f. (City or town) (County) (State) <b>Baltimore, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>8/15/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 19, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brooklands of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Philip E. Crach</b>		ADDRESS <b>1211 Choseco Ave.</b>	
25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

8/20/52

1232

UNITED STATES DEPARTMENT OF AGRICULTURE

1. Name

2. Address

3. Telephone

4. Business

5. City

6. State

7. Zip

8. Date

9. Time

10. Remarks

11. Name of person to whom called

12. Title

13. Position

14. Organization

15. Address of person to whom called

16. City

17. State

18. Zip

19. Date of call

20. Time of call

21. Duration

22. Purpose

23. Result

24. Name

25. Title

26. Signature

27. Remarks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																		
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																		
CERTIFICATE OF DEATH																		
1. DECEASED-NAME (Type or print)			First Harold			Middle M.			Last Cummins, Sr.			2a. DATE OF DEATH Month Aug. 18, 1967			2b. HOUR M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH July 19, 1898			6. AGE (In years last birthday) 69 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.									
1d. CITY OR TOWN OF DEATH Towson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Valley Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Building Contractor			12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY --			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 12 W. 24th Street #18						
14. FATHER'S NAME First Robert			Middle P.			Last Cummins			15. MOTHER'S MAIDEN NAME First Maryl			Middle E. Macneal			Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 212-01-2108			17. INFORMANT Mrs. Irma C. Cummins			Address 12 W. 24th St. 18						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of tongue with metastases</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2Db. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State												
22a. I certify that (I) (this hospital) attended the deceased from <u>March 30, 1967</u> , to <u>Aug. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 18, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <u>L. Myrton E. Gines, Jr.</u>			M.D. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/>			STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3/19/68			
22d. PHYSICIAN'S NAME (Type) <u>L. Myrton E. Gines, Jr.</u>			22e. ADDRESS <u>7800 York Rd. - Towson, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 8/21/1967			23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			23d. LOCATION (City or Town) (County) (State) Woodlawn, Md.									
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons			ADDRESS North & Pa. Balto. Md.			25a. REC'D BY REGISTRAR DATE Jul 24, 1968			25b. REGISTRAR'S SIGNATURE J. Charles Judge									

11

1-1-31



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10574

10574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>Baltimore 21218</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>510 E. 39th St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nellie A. CURRAN</b>		4. DATE OF DEATH Month Day Year <b>August 15, 19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1886</b>	9. AGE (In years lost birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Michael Kenny</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Morrison</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charles C. Doud Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute gastro intestinal hemorrhage cause</b> DUE TO <b>undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary thrombosis, acute</b> DUE TO (c) <b>Generalized arteriosclerosis.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 8, 19 67</b> , to <b>August 15, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 15, 19 67</b> , and that death occurred at <b>9:45M</b> , from causes and on the date stated above.					
22. SIGNATURE <b>Teodula Paglinauan, Jr.</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 15, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Teodula Paglinauan, Jr., M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-18-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cayhedral</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>		ADDRESS <b>6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

UNITED STATES DEPARTMENT OF AGRICULTURE

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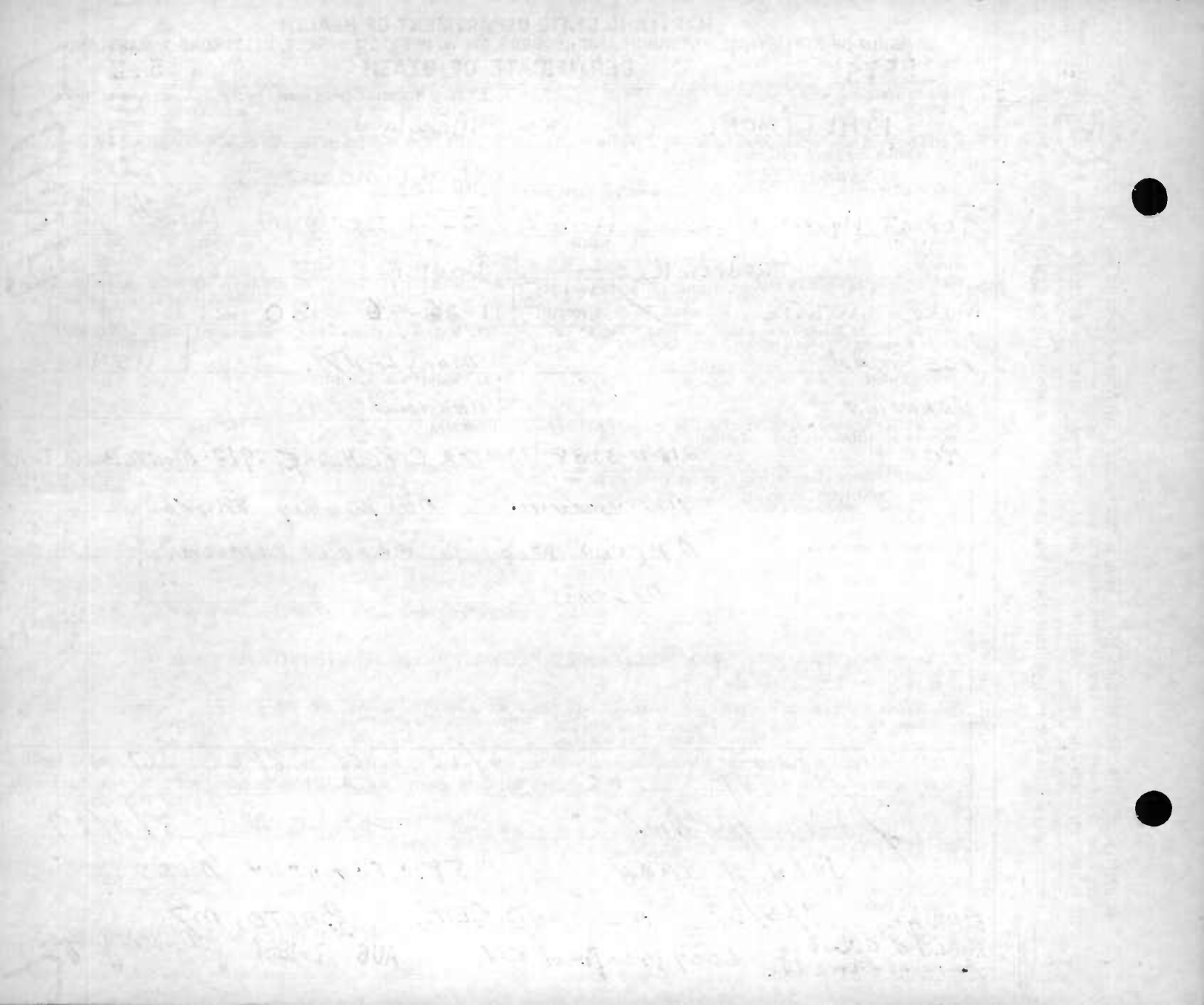
UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10575  
CERTIFICATE OF DEATH  
10575

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>304</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forest Haven Nursing Home</b>				d. STREET ADDRESS <b>3501 Berwyn Ave</b>			
3. NAME OF DECEASED (Type or print) <b>Frederick — Dagler</b>				4. DATE OF DEATH <b>8 2 1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-26-86</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ICE-MAN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>218-18-3338</b>		17. INFORMANT <b>WALTER C. RICHWINE</b> Address <b>2912 MONTEBELLO TERR</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Pneumonia - pneumoniae</b> DUE TO (b) <b>Anterior Ischemic Cardiac Necrosis</b> DUE TO (c) <b>Disease</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/26</b> , 1966, to <b>8/2</b> , 1967, that (I) (we) last saw the deceased alive on <b>8/1</b> , 1967, and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Shaw</b>				22b. DATE SIGNED <b>8/2/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW</b>				22d. ADDRESS <b>5800 EDWARDS AVE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND CEM.</b>		23d. LOCATION (City, town or county) (State) <b>BALTO, MD.</b>	
24. FUNERAL DIRECTOR <b>Robert C. Utterberg Funeral Home Inc</b> ADDRESS <b>6009 Hanford Rd.</b>				25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10576

10576

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>14 months 10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>2249 Sidney Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN DANIEL</b> Middle <b>DAVIS</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>8</b> / Day <b>27</b> / Year <b>1967</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/11/90</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mail carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Davis</b>				14. MOTHER'S MAIDEN NAME <b>Ida Randolph</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>23 5-54-2087</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced pulmonary tuberculosis</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic obstructive airway disease, severe</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/17/1967</b> to <b>8/27/1967</b> , that (I) (we) last saw the deceased alive on <b>8/27/1967</b> , and that death occurred at <b>11:54 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>W. Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8.28.1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>				22d. ADDRESS <b>Mt. Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Marshville Baptist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Marshville, W. Va.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DATE

PLACE

WITNESSES

NAME

AGE

SEX

RACE

DECEASED

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DECEASED

DATE OF DEATH

PLACE OF DEATH



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10577

10577

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>30-4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>#21212</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>903 Woodburn Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Caroline Elizabeth Dibble</b>		4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 29, 1877</b>
9. AGE (In years lost birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Gamber, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Lindsay</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ogg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Luther L. Dibble</b>		Address <b>807 Evesham Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4200</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE (DECOMPENSATED)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 30, 1967</b> to <b>August 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 1, 1967</b> , and that death occurred at <b>12:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ramon P. Lopez</b>		22b. DATE SIGNED <b>August 1, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ramon P. Lopez, M.D.</b>		22d. ADDRESS <b>7620 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug 4, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Carroll Co. Md</b>	
24. FUNERAL DIRECTOR <b>BURGE FURKAL</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 4 1967</b>	

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

January 1, 1900

TO THE HONORABLE SENATE

AND THE HONORABLE HOUSE OF REPRESENTATIVES

OF THE UNITED STATES OF AMERICA

REPORT

ON THE

PROGRESS OF THE

DEPARTMENT OF JUSTICE

FOR THE YEAR

ENDING DECEMBER 31, 1899

AND THE

REVENUE OF THE

DEPARTMENT OF JUSTICE

FOR THE YEAR

ENDING DECEMBER 31, 1899

AND THE

REVENUE OF THE

DEPARTMENT OF JUSTICE

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		FORT HOWARD		c. LENGTH OF STAY IN 1b		86 DAYS		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		VETERANS ADMINISTRATION HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		ANNAPOLIS		ANNE ARUNDEL	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
PARRISH		NMN		DIGGS		AUGUST		10 19 67	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11/25/12	55/54 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
LABORER		CONSTRUCTION		BALTIMORE, MARYLAND		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
JAMES S. DIGGS				ELEANOR SIMMS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
YES		WW II		214 05 19 66		CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 FRACTURE OF THE NECK OF THE LEFT FEMUR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED?	
PARKINSON'S DISEASE - TERMINAL BRONCHOPNEUMONIA								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Fell at home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 14 67 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town)		(County) (State)	
						ANNAPOLIS, ANNE ARUNDEL, MD.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						22. DATE SIGNED	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						8/10/67	
MELVIN DAVIS, M. D., MORNINGTON ROAD, BUNDALK, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		8/13/67		JOHN WESLEY CEMETERY		WATERBURY, MARYLAND			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C.E. Hicks, 111		HICKS FUNERAL HOME		AUG 15 1967		Charles Judge			
		45 N. WEST ST. ANNAPOLIS, MD.							

• • HICKS, J. I.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10579									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b <b>2 Wks.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shangri-La Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>5219 Windsor Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Walter M.</b> Middle <b>Disney</b> Last <b>Disney</b>					4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 67</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 29, 1878</b>		9. AGE (In years last birthday) <b>89</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bottling Dept.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Royal Farm Dairy</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Nelson Kellogg Disney</b>					14. MOTHER'S MAIDEN NAME <b>Georgeanna Stephen</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>215-09-2405</b>		17. INFORMANT <b>Marvin Disney, Sr.</b> Address <b>1647 Langford Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Severe varicose ulcerations over both lower legs.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>this doctor</del> attended the deceased from <b>August 16, 1967</b> , to <b>August 30, 1967</b> , that (I) <del>was</del> last saw the deceased alive on <b>August 30, 1967</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Millard T. Traband, Jr.</b>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Sept. 1, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>					22d. ADDRESS <b>1811 North Rolling Road, Baltimore, Md. 21207</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-2-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Hill</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>G. Howard Strong</b> ADDRESS <b>3207 W. North Ave.,</b>					25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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## CERTIFICATE OF DEATH

10580

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10580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation.

1. NAME OF DECEASED (Type or Print) William W. Dixon			2. DATE AND HOUR OF DEATH August 22, 1967 5:45 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND BALTIMORE COUNTY FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE - 29 638 North Bend Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - 29 D. STREET ADDRESS (If rural, give location) 638 North Bend Road		
5. SEX M	6. RACE Cauc.	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Sept. 29/90	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Samuel Dixon		
14. MOTHER'S MAIDEN NAME Mary Crow			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Marie White 638 North Bend Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH (A) <i>Massive Intracerebral Hemorrhage</i> DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> (B) <i>Diabetes Mellitus</i> DUE TO (C)		
INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			22. I certify that (I) (this hospital) attended the deceased from 1-13-1960 to 8-22-1967 that (I) (we) last saw the deceased alive on 8-22-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <i>Harry L. Knipp</i> M.D. 23C. PHYSICIAN'S NAME (Type) Harry L. Knipp			23B. DATE SIGNED 8-23-67 M.D. 4116 Edmondson Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 8/25/67		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE RECEIVED BY HEALTH DEPT. AUG 29 1967		25B. NAME OF REGISTRAR <i>Charles Judge</i>	
25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		ADDRESS			

100000

Date		Description		Amount	
1911	Jan 1	Balance		100000	
1911	Jan 15	Interest		1000	
1911	Feb 1	Interest		1000	
1911	Feb 15	Interest		1000	
1911	Mar 1	Interest		1000	
1911	Mar 15	Interest		1000	
1911	Apr 1	Interest		1000	
1911	Apr 15	Interest		1000	
1911	May 1	Interest		1000	
1911	May 15	Interest		1000	
1911	Jun 1	Interest		1000	
1911	Jun 15	Interest		1000	
1911	Jul 1	Interest		1000	
1911	Jul 15	Interest		1000	
1911	Aug 1	Interest		1000	
1911	Aug 15	Interest		1000	
1911	Sep 1	Interest		1000	
1911	Sep 15	Interest		1000	
1911	Oct 1	Interest		1000	
1911	Oct 15	Interest		1000	
1911	Nov 1	Interest		1000	
1911	Nov 15	Interest		1000	
1911	Dec 1	Interest		1000	
1911	Dec 15	Interest		1000	
1911	Dec 31	Interest		1000	
1912	Jan 1	Balance		100000	
1912	Jan 15	Interest		1000	
1912	Feb 1	Interest		1000	
1912	Feb 15	Interest		1000	
1912	Mar 1	Interest		1000	
1912	Mar 15	Interest		1000	
1912	Apr 1	Interest		1000	
1912	Apr 15	Interest		1000	
1912	May 1	Interest		1000	
1912	May 15	Interest		1000	
1912	Jun 1	Interest		1000	
1912	Jun 15	Interest		1000	
1912	Jul 1	Interest		1000	
1912	Jul 15	Interest		1000	
1912	Aug 1	Interest		1000	
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1912	Oct 1	Interest		1000	
1912	Oct 15	Interest		1000	
1912	Nov 1	Interest		1000	
1912	Nov 15	Interest		1000	
1912	Dec 1	Interest		1000	
1912	Dec 15	Interest		1000	
1912	Dec 31	Interest		1000	

10581

## CERTIFICATE OF DEATH

10581

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baynesville</u>		c. LENGTH OF STAY IN 1b <u>1yr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6625 Wycombe Way</u>		d. STREET ADDRESS <u>6625 Wycombe Way 12</u>	
3. NAME OF DECEASED (Type or print) <u>Agnes K. Doyle</u>		4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-1890</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rolfe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Gill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-22-6266</u>	
17. INFORMANT <u>Mr Joseph C. Doyle</u>		Address <u>105 Elinor Avenue 36</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>Hypertension and Terminal CVA</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Marked Obesity.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> ot work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1967</u> , to <u>8-18, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1967</u> , and that death occurred at <u>6:00 p.m.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>John C. Hyle</u>		22b. DATE SIGNED <u>8-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		22d. ADDRESS <u>7527 Belair Rd Balto 36 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-21-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		ADDRESS <u>36 7401 Belair Rd</u>	
25a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO THE DIRECTOR OF THE BUREAU OF THE ARMY  
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY  
SUBJECT: [Illegible]

[Illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23b Film #G391 8/8/67 ph

10582

CERTIFICATE OF DEATH

10582

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> c. LENGTH OF STAY IN lb <b>9 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> d. STREET ADDRESS <b>906 NORTH EDEN ST. BALTIMORE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>SULLIVAN</b> First <b>NMI</b> Middle <b>DUCEE</b> Last 5. SEX <b>MALE</b> 6. COLOR OR RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>RACE TRACK</b> 11. BIRTHPLACE (County & State, or foreign country) <b>NEW ORLEANS, LA.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 13. FATHER'S NAME <b>THOMAS DUCREE</b> 14. MOTHER'S MAIDEN NAME <b>FRANCES (UNKNOWN)</b>			4. DATE OF DEATH <b>AUGUST</b> Month <b>MD.</b> Day <b>1</b> Year <b>19 67</b> 9. AGE (In years lost birthday) <b>70</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b> 16. SOCIAL SECURITY NO. <b>437 07 50 79</b> 17. INFORMANT <b>CLINICAL RECORDS VAH FORT HOWARD, MARYLAND</b> Address _____		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>443X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE PULMONARY EMBOLI</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 23</b> , 19 <b>67</b> , to <b>AUGUST 1</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>AUGUST 1</b> , 19 <b>67</b> and that death occurred <b>11:20 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>John D. Talbert</b> 22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>			22b. DATE SIGNED 22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>8/4/67</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND</b>			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <b>JOE KNIGHT FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>AUG 3 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
ADDRESS <b>1639 BROADWAY BALTIMORE, MARYLAND</b>					

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U. S. DEPARTMENT OF AGRICULTURE

DOI: 10.1002/for



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10583 CERTIFICATE OF DEATH 10583											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN b. <b>5 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Stella Maris Hospice</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md</b> f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> g. STREET ADDRESS <b>3100 St. Paul St</b> h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Marie Celeste Duffy</b> First Middle Last						4. DATE OF DEATH <b>8/24/67</b> Month Day Year					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/18/91</b>		9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>				11b. KIND OF BUSINESS OR INDUSTRY <b>Tuerkes</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John J. Duffy</b>						14. MOTHER'S MAIDEN NAME <b>Armanda R. Duffy (Nee Sedicum)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-05-2161</b>		17. INFORMANT <b>Hospice records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (b) <b>ASCVD</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>5/11/62</b> , 19... to <b>8/24/67</b> , 19..., that (I) (we) last saw the deceased alive on <b>8/22/67</b> , 19..., and that death occurred at <b>8:15A</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert J. Mahon</b>						22b. DATE SIGNED <b>8/24/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						23b. DATE THEREOF <b>8/26/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>						25a. REC'D BY REGISTRAR <b>4905 York Road Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

CONTINUATION OF DEATH

ALL DEATHS

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10584

10584

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN lb <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>5 B. Byway South</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>R</b> Last <b>EVERETT</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAR 15, 1915</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WELDER</b>		11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>	
13. FATHER'S NAME <b>JOHN L. EVERETT</b>		14. MOTHER'S MAIDEN NAME <b>SALLY WEBER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>214-07-457</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable gunshot wound of head</b> DUE TO (b) <b>976X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Probably shot self</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ? ? 19 p.m. ?	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>woods</b>	20f. (City or town) (County) (State) <b>Middle River BALTIMORE MD.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b>		22. DATE SIGNED <b>September 1, 1967</b>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>SEPT. 9, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR CEM</b>	23d. LOCATION (City or Town) (County) (State) <b>BEL AIR MD</b>
24. FUNERAL DIRECTOR <b>J.G. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MACE</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



CERTIFICATE OF DEATH

10585

10585

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>12 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>3413 O'Donnell Street</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WILLIAM</b> Last <b>FIELDS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/93</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Fields</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Kaiser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-05-54-50</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, ACUTE</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS. ARTERIOLAR GLOMERULOSCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 18, 1967</b> , to <b>August 30, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 30, 1967</b> , and that death occurred at <b>5:30AM</b> from causes and on the date stated above.			
22a. SIGNATURE <i>George Dudas</i>		22b. DATE SIGNED <b>8/30/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Sept. 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>BERNARD DABROWSKI</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <b>SEP 6 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1944

Baltimore

Baltimore

Baltimore

12 Days

Fort Howard

3113 O'Donnell Street

Veterans Administration Hospital

63

30

AUGUST

WINDS

WILLIAM

GEORGE

18

5/2/93

XX

White

Male

Crown Cork & Seal Co. Baltimore, Maryland U.S.A.

Grand

Marie Kaiser

William Fields

215-05-54-50 Clin. Rec. VA Hospital, Fort Howard, Md.

W. I

Yes

GENERAL INVESTIGATION

YORK

GENERAL INVESTIGATION

GENERAL INVESTIGATION

August 18 07

2:30PM

August 30 07

Fort Howard, Maryland

GENERAL INVESTIGATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10586

10586

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, 21204</b> c. LENGTH OF STAY IN 1b <b>4 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Towson Convalescent Home</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville, Maryland 21030</b> d. STREET ADDRESS <b>Oak Knoll Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie Laura</b> Middle <b>Fink</b> Last <b>Fink</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 March 1883</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>4</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Nelson Frederick</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Garrett Frederick</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>220-30-5446</b>		17. INFORMANT <b>Mrs. June Good, Daughter</b> Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , to <b>August</b> , 1967, that (I) (we) last saw the deceased alive on <b>21 August</b> 1967, and that death occurred at <b>10A.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Walter T. Kees</b>		22b. DATE SIGNED <b>22 August 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter T. Kees, M. D.</b>		22d. ADDRESS <b>Cockeysville, Maryland 21030</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 25, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>PARKVILLE, MD.</b>	
24. FUNERAL DIRECTOR <b>John Burnie Lowe, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10587 CERTIFICATE OF DEATH 10587			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1yr7mth23dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3533 Wilkens Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Minnie (Fischer)</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1886</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min. <b>_____</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>_____</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <del>Frederick Reuwer</del> <b>Frederick Reuwer</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address <b>_____</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO (b) <b>Arteriosclerotic cardiovascular heart dis</b> 1 yr. DUE TO (c) <b>Arteriosclerosis, generalized, senile</b> 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>_____</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from <b>Dec. 29, 1955</b> to <b>Aug. 22, 1967</b> , that (we) last saw the deceased alive on <b>Aug. 22, 1967</b> , and that death occurred at <b>4:30 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1944

UNITED STATES

Memorandum

TO: Mr. Tolson

FROM: Mr. E. A. Tamm

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10588 CERTIFICATE OF DEATH 10588									
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4508 Forest View Avenue</i>					d. STREET ADDRESS <i>4508 Forest View Avenue</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry A Fisher Sr.</i>					4. DATE OF DEATH Month Day Year <i>Aug. 5, 1967</i> 19				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 8, 1897</i>		9. AGE (in years last birthday) <i>69</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printing Dept.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>American Oil Co.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Fisher</i>					14. MOTHER'S MAIDEN NAME <i>Anna Gephart</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>213-03-3838</i>		17. INFORMANT Address <i>Mrs. Ethel Naomi Fisher-4508 Forest View Ave</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>151X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Carcinoma of Stomach</i> DUE TO (c) <i></i>								INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> <i>6 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , to <i>8/5</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>8/4</i> , 19 <i>67</i> , and that death occurred at <i>12:30</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>Paul G. Mueller</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>8/5/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Paul G. Mueller</i>					22d. ADDRESS <i>4311 Belair Rd.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <i>8-8-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>John C. Miller Inc-415 Belair Rd.-21206</i>					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J Charles Judge</i>		
					DATE <i>AUG 8 1967</i>				

1952

1. The first part of the report is a general survey of the situation in the country. It is a very interesting and informative survey, and it is well worth reading. It gives a very good idea of the current situation in the country, and it is a very good starting point for further study.

2. The second part of the report is a detailed study of the economic situation in the country. It is a very thorough and detailed study, and it is well worth reading. It gives a very good idea of the current economic situation in the country, and it is a very good starting point for further study.

3. The third part of the report is a detailed study of the social situation in the country. It is a very thorough and detailed study, and it is well worth reading. It gives a very good idea of the current social situation in the country, and it is a very good starting point for further study.



4. The fourth part of the report is a detailed study of the political situation in the country. It is a very thorough and detailed study, and it is well worth reading. It gives a very good idea of the current political situation in the country, and it is a very good starting point for further study.

5. The fifth part of the report is a detailed study of the cultural situation in the country. It is a very thorough and detailed study, and it is well worth reading. It gives a very good idea of the current cultural situation in the country, and it is a very good starting point for further study.

6. The sixth part of the report is a detailed study of the environmental situation in the country. It is a very thorough and detailed study, and it is well worth reading. It gives a very good idea of the current environmental situation in the country, and it is a very good starting point for further study.



10589

## CERTIFICATE OF DEATH

10589 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>LINTAICUM AIRGHTS, MD 022</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>507 LYMAN ST.</b>	
3. NAME OF DECEASED (Type or print) <b>NADINE</b> First <b>LAVERA</b> Middle <b>FLANNERY</b> Last		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/21/13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housewife Clerk (Dry-Cleaning)</b>		9. AGE (In years last birthday) yrs. <b>54</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>
13. FATHER'S NAME <b>HARVEY CLARK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>MARY GRIMM</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral spontaneous pneumothorax.</b> DUE TO (b) <b>Pulmonary Emphysema.</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/17/1967</b> , to <b>8/25/1967</b> , that (I) (we) last saw the deceased alive on <b>8/27/1967</b> , and that death occurred at <b>5A.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Brooklyn (RED) Md-</b>
24. FUNERAL DIRECTOR <b>R.W. English Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Glen Burnie, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>AUG 30 1967</b>	

280

(1942-43) 1/2

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David Aug. 21/1967 Cedar Hill Cem.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

10590

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10590

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>21yr4mth4dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>304</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1622 Johns Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ruth V. = Forbes</b>				4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1967</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1883</b>		9. AGE (In years last birthday) yrs. <b>83</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>_____</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Willard Owens</b>				14. MOTHER'S MAIDEN NAME <b>Leah Bussells</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>_____</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-18-5852J1</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>_____</b>						INTERVAL BETWEEN ONSET AND DEATH <b>_____</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>_____</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>_____</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>_____</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f. (City or town) (County) (State) <b>_____</b>	
21. I certify that <b>she</b> (this hospital) attended the deceased from <b>April 5, 1946</b> , to <b>Aug. 9, 1967</b> , that <b>she</b> (we) last saw the deceased alive on <b>Aug. 9, 1967</b> , and that death occurred at <b>6:45</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Ramon A. Boza, M.D.</b>				22b. DATE SIGNED <b>8-9-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Ramon A. Boza, M.D.</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>				22e. <b>_____</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>W. L. Tuckner &amp; Sons</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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RECORDS OF DEATH

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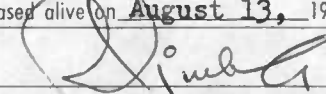
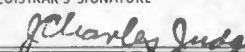
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10591

## CERTIFICATE OF DEATH

10591

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>514 N. Decker Ave. #21205</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>A.</b> Last <b>Freburger</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Esposito</b>		14. MOTHER'S MAIDEN NAME <b>Mary Trautner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Edward Getz, 3531 Woodring Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra-cerebral hemorrhage.</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>8-12-</b> , 19 <b>67</b> , to <b>8-13-</b> , 19 <b>67</b> , that <b>1</b> (we) last saw the deceased alive on <b>August 13</b> , 19 <b>67</b> , and that death occurred at <b>9:15</b> a.m., from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>August 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/16/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore, Md. Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road.</b>		25a. REC'D BY REGISTRAR <b>AUG 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0202



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10592

CERTIFICATE OF DEATH

10592

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>530 Brook Road #4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Valley Cinv. Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene French</b>		4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-22-1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>89 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Grand Rapids Mich.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick V. Lyon</b>		14. MOTHER'S MAIDEN NAME <b>Florence Mae Graham</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Helen French 530 Brook Road #4</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE SECONDARY ANEMIA</b> DUE TO <b>159X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GASTRO-INTESTINAL HEMORRHOGE</b> DUE TO (c) <b>GASTRO-INTESTINAL MALIGNANCY</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>1 YEAR</b> <b>1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTENSIVE &amp; CORONARY HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>12/5, 1962</b> to <b>8/15, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>8/14, 1967</b> , and that death occurred at <b>6:20 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Donald L. Somerville</b>		22b. DATE SIGNED <b>8/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD L. SOMERVILLE, M.D.</b>		22d. ADDRESS <b>25 W. PA. AVE. TOWSON, MD 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Myak N.Y.</b>
24. FUNERAL DIRECTOR <b>Loseal Funeral Home 7401 Belair Road</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

7-240734

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10593														
CERTIFICATE OF DEATH														
Item #2 infer, taken from birth cert, ph														
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b> d. STREET ADDRESS <b>703 North Bend Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>FRIEDEL</b>					4. DATE OF DEATH Month <b>8</b> Day <b>25</b> Year <b>1967</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/25/67</b>		9. AGE (In years last birthday) yrs. <b>11</b> IF UNDER 1 YEAR Months <b>11</b> IF UNDER 24 HRS. Hours <b>11</b> Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>			11. BIRTHPLACE (County & State, or foreign country) <b>--</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>Charles Thomas Friedel</b>					14. MOTHER'S MAIDEN NAME <b>JOYCE Bay</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>			16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Patient's Chart</b>			Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PRIMARY APNEA -</b> 7620 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>ETIOLOGY UNDETERMINED.</b> DUE TO (c) <b>UNDETERMINED.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>11 m.</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>8/25</b> , 19 <b>67</b> , to <b>8/25</b> , 19 <b>67</b> , that <del>the</del> (we) last saw the deceased alive on <b>8/25</b> , 19 <b>67</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Neil H. Kolsky</b>					22b. DATE SIGNED <b>8/27/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>NEIL H. KOLSKY M.D.</b>					22d. ADDRESS <b>GREATER BALTIMORE MED CENTER</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>8/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Josephs</b>			23d. LOCATION (City, town or county) (State) <b>Texas Md.</b>						
24. FUNERAL DIRECTOR <b>John Burns Sons</b>					25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>					25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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## CERTIFICATE OF DEATH

10594

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>County</b>	
c. LENGTH OF STAY IN lb <b>Hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21222 (Dundalk)</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>1957 Quentin Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Michael</b> Last <b>Frieze</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1967</b>	9. AGE (In years last birthday) yrs. <b>6</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>24</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Harold Leslie Frieze</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Father, Mr. Harold L. Frieze, #2, a, b, c, d.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Atelectasis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/4/</b> , 19 <b>67</b> , to <b>8/4/</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/4/</b> , 19 <b>67</b> , and that death occurred at <b>12:56</b> from causes on and on the date stated above.					
22a. SIGNATURE <b>Jose A. Aguto</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>P.M.</b>		22b. DATE SIGNED <b>8/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jose A. Aguto, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>August-7-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION (City or Town) (County) (State) <b>Dundalk, Maryland 21222</b>	
24. FUNERAL DIRECTOR <b>JOHN J. DUDA, Dundalk, Maryland 21222</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1924-1925 (1924)

1926-1927 (1926)

1928-1929 (1928)

1930-1931 (1930)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>17 Yrs.</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Zone 21229</u> <u>031</u> d. STREET ADDRESS <u>705 Charing Cross Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>George F. Fromm</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>August 1, 1967</u> Month Day Year						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 22, 1910</u> <u>57</u> yrs.		<b>9. AGE</b> (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Purchaser</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Koppers Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>			
<b>13. FATHER'S NAME</b> <u>George W. Fromm</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Stegman</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-05-3538</u>		<b>17. INFORMANT</b> <u>Mrs. Ruth C. Fromm</u>		<b>Address</b> <u>Baltimore, Z.29. 705 Charing Cross</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Alkalosis</u> (b) <u>Cerebral Pressure secondary to</u> (c) <u>Brain Tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June, 1967</u> , <b>to</b> <u>1 Aug, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>1 Aug 1967</u> , <b>and that death occurred at</b> <u>6:50 AM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>William J. Bryson</u> <b>22c. PHYSICIAN'S NAME (Type)</b>					<b>22b. DATE SIGNED</b> <u>3 Aug 67</u>		<b>22d. ADDRESS</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Aug. 4, 1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore, Maryland</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Sterling Funeral Estate-736 Edmondson Ave. Catonsville, Md.</u>					<b>25a. REC'D BY REGISTRAR</b> <u>AUG 7 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10596

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10596

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN TB <b>15 Months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2910 Liberty Parkway</b>		d. STREET ADDRESS <b>2910 Liberty Parkway</b>	
3. NAME OF DECEASED (Type or print) <b>W. Wingate Gallaway</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/16/98</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months <b>03</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Open Hearth- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard J. Gallaway</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Nutt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-4101</b>	
17. INFORMANT (Wife) <b>Mrs. Dorothy Gallaway, 2910 Liberty Parkway</b>		Address <b>Dundalk, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221 A-S-C-V-DISEASE</b> IMMEDIATE CAUSE (a) <b>4221</b> DUE TO (b) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>4221</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>8 / 6 / 67</b>	
ACTUAL SIGNATURE <b>M B Davis</b> EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Md. 21222</b> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8 & 9 Film G391 8/21/67 kk

10597

10597

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown Balto.</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7924 Dunhill Village Circle Apt 201</u>		d. STREET ADDRESS <u>7924 Dunhill Village Circle</u>	
3. NAME OF DECEASED (Type or print) SARAH <del>GERBER</del> (FORMAN) GERBER		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Isaac Forman</u>	
14. MOTHER'S MAIDEN NAME <u>Celia ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Samuel Gerber--7924 Dunhill Village Circle</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>  </u> to <u>8/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 1967</u> , and that death occurred at <u>12:45</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Milton Kirsh</u>		22b. DATE SIGNED <u>8/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MILTON KIRSH</u>		22d. ADDRESS <u>4000 W. Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS INC. 6010 Reist Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

10537

RECEIVED THE SECRETARY OF THE ARMY WASHINGTON

OFFICE OF THE SECRETARY

DATE: 1954 JAN 14 AM 10 10

TO: THE SECRETARY

FROM: THE SECRETARY

SUBJECT: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10598

CERTIFICATE OF DEATH

10598

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handlits town</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. CO. GEN. Hosp.</u>		d. STREET ADDRESS <u>3605 A SYLVAN Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>CAROLYN MAE Gerold</u>		4. DATE OF DEATH <u>8-7-1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>G. Frederick Fuegel</u>		14. MOTHER'S MAIDEN NAME <u>Annie Quitt Lobert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WWII</u>		16. SOCIAL SECURITY NO. <u>GUSTAV A. Gerold</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure, Chronic</u> DUE TO (b) <u>H.C.V.D.; Cardio Resp. Insuff.</u> DUE TO (c) <u>ATHEROSCLEROSIS, GENERALIZED</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>STROKE, Dehydration, FOCAL HEMORRHAGE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BRAIN STEM BASAL GANGLIA</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-28-1967</u> , to <u>8-2-1967</u> , that (I) (we) last saw the deceased alive on <u>8-7-1967</u> , and that death occurred at <u>3:45 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Rolando A. Madamba</u> M.D.		22b. DATE SIGNED <u>8-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-10-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Elkworth ARMACOST - 4600 Liberty Hgts Ave</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>AUG 8 1967</u>	

2030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10599

CERTIFICATE OF DEATH

10599

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Summitt Nursing Home</b>		d. STREET ADDRESS <b>4902 Stafford St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>Gilchrist</b> Last <b>_____</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1895</b>
9. AGE (In years last birthday) yrs. <b>72</b>		IF UNDER 1 YEAR Months <b>_____</b> Days <b>_____</b> Hours <b>_____</b> Min. <b>_____</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas Gilchrist</b>	
14. MOTHER'S MAIDEN NAME <b>Catherine Hayes</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes WW I</b>	
16. SOCIAL SECURITY NO. <b>213-14-0730</b>		17. INFORMANT <b>Margaret Seymour</b> <b>4902 Stafford St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY ARTERIOSCLEROSIS</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>_____</b> DUE TO <b>_____</b> (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH <b>17 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Esophageal Stenosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>_____</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> , 19 <b>67</b> , to <b>8/23</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>8/22</b> , 19 <b>67</b> , and that death occurred at <b>1A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas E. Roach</b>		22b. DATE SIGNED <b>8/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas E. Roach, M. D.</b>		22d. ADDRESS <b>5550 Baltimore National Pike</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke F. D. - 4101 Edmondson Ave.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

10232

CERTIFICATE OF SALE

OFFICE OF THE COMMISSIONER OF LANDS AND MINES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10601

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10601

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodholme Apts., Apt A</u>				d. STREET ADDRESS <u>Woodholme Apts., Apt A</u>			
3. NAME OF DECEASED (Type or print) First <u>Meyer</u> Middle <u>B.</u> Last <u>Goldstein</u>				4. DATE OF DEATH Month <u>14</u> , Day <u>14</u> , Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 27, 1902</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barnet Goldstein</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-0139</u>		17. INFORMANT <u>Mrs. Lillian Goldstein, 8001 Woodgate Ct.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thromboses</u> DUE TO (b) <u>A.S.H.P.</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>6/11, 1960</u> to <u>present</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Bernard Burgin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bernard Burgin</u>				22d. ADDRESS <u>6721 Reisterstown Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chafetz Chaim</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10600

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN lb <b>Baltimore</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6649 Wycombe Way</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MORRIS GOLDSTEIN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1901</b>	
9. AGE (In years lost birthday) <b>66 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Solomon</b>				14. MOTHER'S MAIDEN NAME <b>Letha</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bertman Goldstein</b> Address <b>4504 Seetha Level Ct</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> DUE TO (b) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>4201</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Abrasions and Contusions of back</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subj. involved in mild automobile accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Unk</b> p.m. <b>8/2</b> 19 <b>67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Baltimore, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>8/5/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/6/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth El</b>		23d. LOCATION (City or Town) (County) (State) <b>Randallstown Md</b>	
24. FUNERAL DIRECTOR <b>Sylvan S. Lewis &amp; Son, Inc. Garrison Md</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

13300

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

[illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
10602					10602					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1019 Wagner Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b> d. STREET ADDRESS <b>1019 Wagner Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MARY ELIZABETH</b> Middle <b>GOODALL</b> Last 4. DATE OF DEATH <b>August 16 19 67</b>					5. SEX <b>Female</b> 6. COLOR OR RACE <b>Cau.</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>April 10, 1915</b> 9. AGE (In years last birthday) <b>52 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Granville B. Hopkins</b>					14. MOTHER'S MAIDEN NAME <b>Helan Hancock</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Robert D. Goodall, Same as # 2</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure, pulmonary oedema</b> 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Anemia, cachexia</b> DUE TO (c) <b>Hypernephroma with multiple metastases</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>12-24 hrs.</b> <b>21 months</b> <b>21 months</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>9/29/49</b> , 19__, to <b>8/15</b> , 19 <b>67</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8/15</b> , 19 <b>67</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Benjamin H. Rutledge</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>8/16/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Benjamin H. Rutledge, M.D.</b>					22d. ADDRESS <b>18 E. Eager Street, Baltimore, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Aug. 18, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church of Messiah Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Gwynedd, Pennsylvania</b>			
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>					25a. REC'D BY REGISTRAR <b>AUG 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10603

April 10, 1912

Dr. J. H. H. H.

Dr. J. H. H. H.

Dr. J. H. H. H.

Dr. J. H. H. H.

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10603

## CERTIFICATE OF DEATH

10603

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY in 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 03-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center.</u>				d. STREET ADDRESS <u>311 Willow Ave 36</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Casper</u> First Middle Last <u>John Gossman</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-93</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>National Casket</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4511</u>		17. INFORMANT <u>Admission sheet</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Ca of buccal mucosa with metastases to distal</u> DUE TO (c) <u>floor, diabetes mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>67</u> , to <u>8/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>67</u> , and that death occurred at <u>7:50 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>J. Narich</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr Galloway</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-10-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, City Md.</u>	
24. FUNERAL DIRECTOR <u>Lassohn Funeral Home 2401 Belair Road</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10604

10604

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>13-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Baptist Home of Md.</b>				d. STREET ADDRESS <b>244 Rodgers Forge Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE RYAN GOULD</b>			4. DATE OF DEATH <b>August 23, 1967</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>March 21, 1870</b>	9. AGE (In years last birthday) <b>97 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert S. Ryan</b>			14. MOTHER'S MAIDEN NAME <b>Annie Boswell</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-54-3476</b>		17. INFORMANT Address <b>Mrs. Elizabeth G. Reitz 244 Rodgers Forge Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Carcinoma of left Breast with metastasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Generalized Arterio Sclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>none</b>					
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>66</b> to <b>Aug. 23, 1967</b> , that <b>we</b> last saw the deceased alive on <b>Aug. 19, 1967</b> , and that death occurred at <b>10:45 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Earl L. Chambers</b>				22b. DATE SIGNED <b>8/25/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl L. Chambers</b>	
22d. ADDRESS <b>4108 Liberty Hgts. Ave. Balto., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>				25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

455

5728 J. Neurosci., September 24, 2008 • 28(39):5723–5731

2119-2121

14 to each trailer.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 to be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

10605 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Item # 8 FilmG392 8/24/67											
CERTIFICATE OF DEATH 10605											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chase						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chase					
c. LENGTH OF STAY IN 1b Life						d. STREET ADDRESS Box 93 Chase, Maryland 21027					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ivy Hall Nursing Home						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ida V. GRAY						4. DATE OF DEATH Month 8 Day 18 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/1898 69 yrs.		AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Homemaker				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Daughtery						14. MOTHER'S MAIDEN NAME Julia Martin					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr Thomas C. Gray Jr. Box 93 Chase, Md. 21027					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 334X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cerebral Vascular Disease											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8/17 to 8/17, 1967 that (I) (we) last saw the deceased elive on 8/17, 1967, and that death occurred at 3:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Samuel Stern M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) SAMUEL STERN						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-21-1967		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION (City, town or county) Baltimore Co. Md.					
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lassahn Funeral Home 7401 Belair Road (36)						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
						DATE AUG 21 1967					

10305

CERTIFICATE OF DEATH

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
AGE  
SEX  
MARRIAGE  
OCCUPATION  
EDUCATION  
RELIGION  
BIRTH  
DEATH  
BURIAL

Autopsy

Medical History

10

DANIEL J. JAMES

AUG 1 1961

Sealed and signed by the Registrar of Deaths

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10606

CERTIFICATE OF DEATH

10606

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>120 DAYS</b>		d. STREET ADDRESS <b>4339 Reisterstown Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS S. GREEN</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 2 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/13/21</b>
9. AGE (In years lost birthday) yrs. <b>45</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WILMINGTON, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES GREEN</b>		14. MOTHER'S MAIDEN NAME <b>MARY REGISTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES ARMY</b>		16. SOCIAL SECURITY NO. <b>213 18 39 91</b>	
17. INFORMANT <b>CLINICAL RECORDS VA HOSPITAL FORT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX AND EPIGLOTTIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 4</b> , 19 <b>67</b> , to <b>AUGUST 2</b> , 1967, that (I) (we) last saw the deceased alive on <b>AUGUST 2</b> , 1967, and that death occurred at <b>12:15 PM</b> causes and on the date stated above.			
22a. SIGNATURE <b>Ahmed Kutty</b>		22b. DATE SIGNED <b>8/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>AHMED KUTTY, M.D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>ARLINGTON S. PHILLIPS</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10606

BARBERS

PORT HOWARD

1st REG

BATTALION

VETERAN'S AIR INFORMATION

#333 miles from

THOMAS

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OTHER

AUGUST

THOMAS

MALE

PATRICK

WINNINGTON, D. C.

U.S.A.

JAMES GREEN

MARY REGISTER

ARMY

1918-1921

CLERICAL WORKER

CLERICAL WORKER

CLERICAL WORKER

CLERICAL WORKER

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CLERICAL WORKER

CLERICAL WORKER



10607

## CERTIFICATE OF DEATH

10607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3602 Clifmar Road</u>		d. STREET ADDRESS <u>3602 Clifmar Road</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Gladys Greenfield</u>		4. DATE OF DEATH <u>August 31</u> , 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct. 12, 1904</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>David Greenfield</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Dembo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		17. INFORMANT <u>Mrs. Dorothea Vospy, 3602 Clifmar Road #7</u>	
18. SOCIAL SECURITY NO.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>157X</u> IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO <u>Compensated &amp; converted</u> (b) <u>Diabetes</u> DUE TO <u>Carcinoma of Pancreas</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>11 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 20, 1946</u> to <u>Aug 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 1967</u> , and that death occurred at <u>10:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Lester Kolman</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Lester Kolman</u>		22d. ADDRESS <u>3700 Park Heights Avenue</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ohel Yakov</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1000

UNITED STATES OF AMERICA

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10608

10608

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>7 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>				d. STREET ADDRESS <b>4555 Shamrock Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Donald Gerald GRIFFITHS</b>				4. DATE OF DEATH Month <b>8</b> Day <b>31</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-58</b>		9. AGE (In years lost birthday) <b>9</b> yrs.		IF UNDER 1 YEAR Months <b>31</b> Days <b>19</b> Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephen Griffiths</b>				14. MOTHER'S MAIDEN NAME <b>Audrey Helene McGee</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4331</b> IMMEDIATE CAUSE (a) <b>Atrial Fibrillation</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>9-25</b> , 19 <b>59</b> , to <b>8-31</b> , 19 <b>67</b> , that (it/we) last saw the deceased alive on <b>8-31</b> 19 <b>67</b> , and that death occurred at <b>9:45 a.m.</b> causes and on the date stated above.							
22a. SIGNATURE <b>Angelio Garcia</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Angelio Garcia, M.D.</b>				22d. ADDRESS <b>Rosewood State Hosp., Owings Mills, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/2/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10003

Baltimore

Large Mills

7 pm.

Baltimore

350 Sparrow Avenue

Missed State House

March 10

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Baltimore, Md.

9/2/67, Holy Redeemer Cemetery

March 10

March 10

March 10

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

10603

10609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>BALTO</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison - Baltimore</u> d. STREET ADDRESS <u>700 N. Lakewood Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>T</u> Middle <u>Hale</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u>		5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-20-1886</u>		9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Delma Stinchcombe</u>						14. MOTHER'S MAIDEN NAME <u>Frances Steward</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-48-4599</u>		17. INFORMANT <u>Gladys Grove, sister, 6709 Mt. Vernon Ave.</u> Address <u>#15</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1750</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of the ovary</u> (c) <u>unknown</u> DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from <u>8-2</u> , 19 <u>67</u> , to <u>8-12</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>67</u> , and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>David I. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <u>8-12-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>				22d. ADDRESS <u>Cruson Rd. - Owings Mills, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u>					
24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> ADDRESS <u>2601-03-05 E. Madison Street #5</u>						25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

100302

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John Stenhouse

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100 N. 1st Street  
Baltimore

Aug 1 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baptist Home of Md.</u>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4407 Falls Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>EMMA E. HALL</u> First Middle Last					<b>4. DATE OF DEATH</b> <u>August 4, 1967</u> Month Day Year						
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 23, 1872</u>		<b>9. AGE (In years last birthday)</b> <u>94</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Somerset Co., Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Aurelius Long</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Ruff</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Baptist Home of Md. Owings Mills, Md.</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> (b) <u>Coronary Vascular Disease</u> (c) <u>Pericardial Anemia. Cardiac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Senility</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>										<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1967 to Aug 4, 1967, that (I) (we) last saw the deceased alive on Aug 4, 1967, and that death occurred at 3:30 PM, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Dr. M. Paul Byerly</u>					<b>22b. DATE SIGNED</b> <u>5/4/67</u>			<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. M. Paul Byerly</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>					<b>23b. DATE THEREOF</b> <u>8-7-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Grace Methodist Church</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Falls Rd Balto. Co. Md</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Mitchell-Wiedefeld Home, Inc.</u> <u>6500 York Rd. Baltimore Md. 21212</u>					<b>25a. REC'D BY REGISTRAR</b> <u>AUG 7 1967</u>					<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/67

10611

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10611

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <b>3 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1414 Putty Hill Road</b>		e. STREET ADDRESS <b>1414 Putty Hill Road</b>	
3. NAME OF DECEASED (Type or print) <b>George Aloysius Hall</b>		4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) <b>77</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Gregory Hall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Casby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>717 07 7414</b>	
17. INFORMANT <b>Geo. R. Hall 967 Spruce St. Pottstown Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>57 yrs.</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		22. DATE SIGNED <b>8/5/67</b>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-8-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland.</b>
24. FUNERAL DIRECTOR <b>Wm. E. Johnson, 8521 Loch Raven Blvd., 21204 Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10011

Bellevue

Bellevue

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1914 July 11th

George Augustus Hall

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Known 1-6

George Augustus Hall

July 17 1914

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*[Faint, illegible handwritten text]*

George Augustus Hall

1914

Bellevue 2144

Bellevue 2144

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10612

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>11mth16dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>2000 Tuckerman Street</b>	
3. NAME OF DECEASED (Type or print) <b>James Nelson Hall</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1893</b>
9. AGE (In years lost birthday) yrs. <b>74</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Instrument Maker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>George Hall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes U.S. Army</b>		16. SOCIAL SECURITY NO. <b>213-24-3853</b>	
17. INFORMANT <b>EMMA HALL</b>		Address <b># 2</b>	
18. RECORDS: <b>SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Porencephalic cyst, left occipital lobe</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral hemorrhage 1965 and 4-1966 treated at V.A.H. - Wash., D.C.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (x) (this hospital) attended the deceased from <b>Sept. 1</b> , 19 <b>66</b> , to <b>Aug. 17</b> , 19 <b>67</b> that (x) (we) last saw the deceased alive on <b>Aug. 17</b> , 19 <b>67</b> , and that death occurred at <b>4:40</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>August 21, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Port Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Aug 28 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10312

in 1910

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George Hall A. 101-102

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1922-1923

1923-1924

1924-1925

1925-1926



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14  
20M 1/63

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b> c. LENGTH OF STAY IN 1b <b>18 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER RD 1 BOX 229</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAYRE de GRACE</b> d. STREET ADDRESS <b>BOX 229</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GLENN B HAMILTON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-3-27</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SERVICE STATION OPERATOR</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>SERVICE STATION</b>	
10a. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		10b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. FATHER'S NAME <b>CHARLES H. HAMILTON</b>		12. MOTHER'S MAIDEN NAME <b>OZELLA PHILLIPS</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>XXXXXX Korean</b>		14. SOCIAL SECURITY NO. <b>220 20 7434</b>	
15. INFORMANT <b>PATIENT'S CHART</b>		16. ADDRESS <b>PATIENT'S CHART</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis of lungs</b> 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>oral carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/26/67</b> , 19 <b>67</b> , to <b>8/27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/27</b> , 19 <b>67</b> , and that death occurred at <b>2:15M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Eduardo M. Canilang</b>		22b. DATE SIGNED <b>8/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDUARDO M. CANILANG</b>		22d. ADDRESS <b>GREATER BALTO. MED. CENTER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>30 Aug. 67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wesleyan Chapel Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Aberdeen, (Harford) Md.</b>	
24. FUNERAL DIRECTOR <b>John E. Tarring</b>		25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10015

CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF INTERVIEWER: [illegible]

NAME OF WITNESS: [illegible]

NAME OF MINISTER: [illegible]

NAME OF CHURCH: [illegible]

NAME OF FUNERAL HOME: [illegible]

NAME OF CEMETERY: [illegible]

NAME OF INTERVIEWER: [illegible]

Funeral Home, 30 Ave. of Wesleyan Chapel Com. Aberdeen, (New York) N.Y.  
Funeral Home, 30 Ave. of Wesleyan Chapel Com. Aberdeen, (New York) N.Y.  
Funeral Home, 30 Ave. of Wesleyan Chapel Com. Aberdeen, (New York) N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10614

CERTIFICATE OF DEATH

10614

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>			c. LENGTH OF STAY IN 1b <b>23 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>1359 WEST NORTH AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LEWIS ADAM HANLEY</b>		First Middle Last		4. DATE OF DEATH <b>AUGUST 6, 1967</b>		Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 7, 1893</b>		9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WYTHE COUNTY, VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>		16. SOCIAL SECURITY NO. <b>719 14 03 06</b>		17. INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO (b) <b>CARCINOMA OF PROSTATE</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 14, 1967</b> , to <b>Aug. 6, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 6, 1967</b> , and that death occurred <b>8:00 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Joan C. Dumlery, Jr.</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/6/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. DUMLER, JR., M.D.</b>				22d. ADDRESS <b>VET. ADM. HOSP., FT. HOWARD, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-9-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>GEORGE G. KELSON FUNERAL HOME</b>				25a. REC'D BY REGISTRAR <b>1346 N. Calhoun St. BALTO. MD.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

10014

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10615 CERTIFICATE OF DEATH 10615											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>209 W. Timonium Road</u>						d. STREET ADDRESS <u>209 W. Timonium Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Patrick</u> Last <u>Hanley</u>						4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 5, 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Patrick Hanley</u>						14. MOTHER'S MAIDEN NAME <u>Rose Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>214-30-4579</u>		17. INFORMANT <u>Family records</u> Address					
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>190.9</u> DUE TO (b) <u>Malignant Melanoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u>	
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> , to <u>Aug 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>15 August 1967</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles W. Council</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Council</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u>				
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>DATE AUG 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

ESTIMATE OF DEATH

10012



CERTIFICATE OF DEATH

10616

10616

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Chapel Hill Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b> d. STREET ADDRESS <b>6412 Windsor Mill Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Howard R. Harr, Sr.</b>				4. DATE OF DEATH <b>August 17 1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 3, 1882</b>		9. AGE (In years last birthday) <b>85 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Examiner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Banking</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob A. Harr</b>				14. MOTHER'S MAIDEN NAME <b>Arabella Waterhouse</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-09-3792</b>		17. INFORMANT <b>Howard R. Harr Jr. 8905 Flagstone Circle Randallstown, Md. 21133</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>1</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3, 1882</b> to <b>8/17/1967</b> , that (I) (we) last saw the deceased alive on <b>8/17/1967</b> , and that death occurred at <b>7:28 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Wm E. Martin</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Wm E. Martin</b>				22b. DATE SIGNED <b>8/18/67</b>			
22d. ADDRESS <b>Liberty Rd. Harrisonville Md.</b>							
23a. BURIAL, CREMATION, <b>BURIAL</b> (Specify)		23b. DATE THEREOF <b>8/21/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Paul's Lutheran Church</b>		23d. LOCATION (City, town or county) (State) <b>Uniontown Carroll Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b> ADDRESS <b>8728 Liberty Rd. Randallstown</b>				25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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10616

Bellevue

Landlady

Charles Hill Nursing Home

Howard

H.

Harry, Jr.

Assisted

17

87

white

Male

Jan. 2, 1982

55

Banking

Religious

U.S.A.

Archie's Restaurant

Jacob J. Hart

210-00-7922

1000 Pinecone Circle  
Landlady, Mr. 210-00-7922

Dr. Wm. S. Hartman

Liberty St. Harrisville, N.H.

Serial

82

Paul's Lutheran Church

Landlady

210-00-7922

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G392 8/25/67 kk

10617

## CERTIFICATE OF DEATH

10617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>24.5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7000 RICHMOND AVE</u> <u>Easton</u> <u>2002</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Homes (Bonnie Blair)</u>				d. STREET ADDRESS <u>15 Harrison Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Clayton</u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-1876</u>		9. AGE (In years lost birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>CRP Telephone</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Market Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Hall Harris</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Hensley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-094</u>		17. INFORMANT <u>Mrs. Henry Masonic Home</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>longstine heart failure</u> DUE TO (c) <u>Pulmonary edema</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 11, 1967</u> to <u>August 11, 1967</u> and that death occurred at <u>1:40 A.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>JAMES H. HANED</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HANED</u>				22d. ADDRESS <u>MASONIC HOME</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug 15, 1967</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Spring Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Easton Md</u>	
24. FUNERAL DIRECTOR <u>W. Cook - Brooks Towson</u>				ADDRESS <u>1050 York Rd Towson, Md</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10617

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

WASHINGTON, D.C.

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

10617

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 2 10618

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10618

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>19 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>921 WHATCOAT STREET</b>	
3. NAME OF DECEASED (Type or print) <b>JAMES HENRY HARRISON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 4, 1894</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ASPHALT BLOCK CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ANNE ARUNDEL CO. MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE HARRISON</b>		14. MOTHER'S MAIDEN NAME <b>MAGGIE MN: UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>218 09 31 25</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC PYELONEPHRITIS</b> DUE TO (b) <b>6000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA. ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/3/67</b> , 19__, to <b>8/22/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/22/67</b> , 19__, and that death occurred at <b>9:55 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>8/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
ADDRESS <b>1348 N. Calhoun St. Baltimore, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>John D. Talbert</b>	

VR A15 (4)  
25M 1/67

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EXHIBIT 100-10018

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CERTIFICATE OF DEATH

10613

10619

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Alleghany Ave.				d. STREET ADDRESS 300 Alleghany Ave.				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lydia E. Hartley				4. DATE OF DEATH August 25, 19 67				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH May 9, 1895 1883			
9. AGE (In years last birthday) 84 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY 214-20-0744 D				11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Benjamin Snyder				14. MOTHER'S MAIDEN NAME Elizabeth Wirsing			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-20-0744D				17. INFORMANT Mrs. Calvin Van Horn (Daughter) Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO INANITION + DEHYDRATION (b) MULTIPLE CEREBROVASCULAR ACCIDENTS (c) CEREBRAL + GENERALIZED ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 1 WIC 2 YEARS YEARS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Towson				20g. (County) Towson				20h. (State) Md.			
21. I certify that (I) (this hospital) attended the deceased from 12/22/62 to 8/25/67, that (I) saw the deceased alive on 8/25/67, and that death occurred 10:00 AM from the causes and on the date stated above.											
22a. SIGNATURE Donald L. Somerville				22b. DATE SIGNED 8/26/67				22c. PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE			
22d. ADDRESS 25 W. PA. AVE TOWSON, MD 21264											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 28, 1967				23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery			
23d. LOCATION (City, town or county) Towson, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE Eugenia K. Seitz				25a. REC'D BY REGISTRAR AUG 28 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			
Seitz Funeral Home Baltimore, Md. 21212											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

21305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10620

CERTIFICATE OF DEATH

10620

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> 031	
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>		d. STREET ADDRESS <u>1223 Birch Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1223 Birch Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence M. Hartman</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/79</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugo Paul</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Weil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Evelyn Rubio</u>		Address <u>1223 Birch Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>107684</u> , 19 <u>  </u> , to <u>82767</u> , 19 <u>  </u> , that (I) (we) lost saw the deceased alive on <u>82567</u> , 19 <u>  </u> , and that death occurred at <u>  </u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Harry Gimbel</u>		22b. DATE SIGNED <u>8-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry Gimbel</u>		22d. ADDRESS <u>4605 Edmondson Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR <u>Amber Inc. 1328 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			

10000

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

U.S. GOVERNMENT PRINTING OFFICE

1. Name of deceased: James M. Harrison  
2. Date of death: April 12, 1968  
3. Place of death: Home  
4. Cause of death: Heart failure  
5. Date of birth: June 15, 1902  
6. Sex: Male  
7. Race: White  
8. Marital status: Married  
9. Occupation: Retired  
10. Signature of physician: [Signature]  
11. Signature of registrar: [Signature]  
12. Date of registration: April 15, 1968  
13. Registrar's name: [Signature]  
14. Registrar's address: [Signature]  
15. Registrar's phone: [Signature]

10000

U.S. GOVERNMENT PRINTING OFFICE

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

10621

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10621

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN lb <b>5 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>229 W. Timonium Road</b>		d. STREET ADDRESS <b>229 W. Timonium Road</b>	
3. NAME OF DECEASED (Type or print) <b>HELEN HARDIN HAUGHTON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1902</b>
9. AGE (In years and birthdays) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C. Hardin</b>		14. MOTHER'S MAIDEN NAME <b>Lettie Pasterfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>7</b>	
17. INFORMANT <b>Holden R. Houghton, Timonium, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>8/4/67</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 8, 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Section 10001-10002  
Section 10003-10004  
Section 10005-10006  
Section 10007-10008  
Section 10009-10010

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Section 10099-10100

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Section 10297-10298  
Section 10299-10300



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

10622

10622

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 031			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2703 Waco Court #8</u>				d. STREET ADDRESS <u>2703 Waco Ct. 8</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>Heft</u> Last <u>Heft</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/30/1925</u>		9. AGE (In years, last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Basketball</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY Heft</u>				14. MOTHER'S MAIDEN NAME <u>ROSE TARANSKY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>519-24-0006</u>		17. INFORMANT <u>WIFE - Mrs. Shirley H. Heft</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> <u>HIGH</u> DUE TO (b) <u>Rheumatic Cl Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August, 1965</u> , to <u>Aug 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1967</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel Legum</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>  </u>		22b. DATE SIGNED <u>8.22.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL LEGUM, M.D.</u>				22d. ADDRESS <u>1261 E. North St. Baltimore 2 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/23/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BNAT ISRAEL</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 PEIST., RD.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10623

10623

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>418 High Meadow Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u> d. STREET ADDRESS <u>418 High Meadow Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary E. Henn</u>		<b>4. DATE OF DEATH</b> <u>Aug. 3 1967</u>		<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 2, 1905</u>		<b>9. AGE</b> (In years last birthday) <u>62</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>03</u> Days <u>1</u> <b>IF UNDER 24 HRS.</b> Hours <u>00</u> Min. <u>00</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY</b> <u>United States</u>	
<b>13. FATHER'S NAME</b> <u>Martin Cloney</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Rackenberg</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>none</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> <u>Mr. James C. Henn</u> Address <u>418 High Meadow Rd.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis - generalized</u> DUE TO (b) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>													
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)													
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, lecture, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>February 1967</u> , <b>to</b> <u>August 3, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>July 31, 1967</u> , <b>and that death occurred</b> <u>Aug. 3, 1967</u> , <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Clarence E. McWilliams</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>August 3/1967</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Clarence Mc Williams</u>		<b>22d. ADDRESS</b> <u>11904 Reisterstown Rd Reisterstown Md.</u>	
<b>23b. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23c. DATE THEREOF</b> <u>Aug. 5, 1967</u>				<b>23d. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven</u>				<b>23e. LOCATION (City, town or county)</b> <u>Glen Burnie A.A. Co Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George J. Louel</u>						<b>25a. REC'D BY REGISTRAR</b> <u>169 RIVIERA DR A.A.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>AUG 7 1967</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>24 North Bernice Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>George</b>		4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1905</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>61</b> Days <b>61</b> Hours <b>61</b> Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John</b>		14. MOTHER'S MAIDEN NAME <b>Susan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-07-3279</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, organism unknown, bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular hypertensive heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 10, 1967</b> , to <b>Aug. 23, 1967</b> , that <input checked="" type="checkbox"/> (we) saw the deceased alive on <b>Aug. 23, 1967</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-23-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR <b>Adolphus Halstead, 1206 W North Ave</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

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CHARTERED BY STATE

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10625

CERTIFICATE OF DEATH

10625

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN 1b <b>3 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Arm</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>Box 420 Notcheliff Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Max Henschel</b>				4. DATE OF DEATH Month Day Year <b>8 18 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/10/1899</b>	
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>18 19 67</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registrar - retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shipping Assn.</b>		13. FATHER'S NAME <b>Morris Henschel</b>	
13. FATHER'S NAME <b>Morris Henschel</b>				14. MOTHER'S MAIDEN NAME <b>Ida ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>130-18-4202</b>		17. INFORMANT <b>Family records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> 2041 DUE TO <b>Chronic myelogenous leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>8/18</b> , 19 <b>67</b> , to <b>8/18</b> , 19 <b>67</b> , that (X) (we) lost saw the deceased alive on <b>8/18</b> , 19 <b>67</b> , and that death occurred <b>5:05 p</b> M, from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 19, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M. D.</b>				22d. ADDRESS <b>7620 York Road, Towson 4, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal Burial Aug. 22, 1967</b>		23b. DATE THEREOF <b>Aug. 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>New Gardens, N.Y.</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 21 1967</b>		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

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St. Joseph Hospital

Box 180 Honolulu, T.H.

Honolulu

Box

Wife

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Wife

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St. Joseph Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10626

CERTIFICATE OF DEATH

10626

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2021 Englewood Ave. 21207</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Irene R. Hertsch</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1895</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Miller</b>		14. MOTHER'S MAIDEN NAME <b>Annie Keller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Frank F. Hertsch Sr. 2021 Englewood Ave #7</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4344</b> IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> DUE TO (b) <b>Cardiac Decompensation</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 1, 1963</b> to <b>August 26, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 26, 1967</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>George E. Shannon</b>		22b. DATE SIGNED <b>Aug. 28, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>George E. Shannon M.D.</b>		22d. ADDRESS <b>412 medical Arts Bldg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balbo Co Md.</b>
24. FUNERAL DIRECTOR <b>Spring Myers 8728 Liberty Rd Randallstown Md</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10627

CERTIFICATE OF DEATH

10627

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE County Gen. Hosp.</u>		d. STREET ADDRESS <u>16 N. Collington Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>—</u> Last <u>HESS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/195</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONEMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AM. SUGAR REF. CO.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>
13. FATHER'S NAME <u>BLACKSMITH</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS. LILLIAN HESS, 16 N. COLLINGTON AVENUE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>myocardial damage</u> DUE TO (c) <u>possible ventricular fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Not Known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>possibly a multi-system disease, pericarditis, nodules</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>not injured</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>7/13/67</u> , 19 <u>67</u> , to <u>8/8/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/8/1967</u> , and that death occurred at <u>9 p</u> M, from causes and on the date stated above.		22a. SIGNATURE <u>M. K HODA</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>K HODA</u>		22b. DATE SIGNED <u>8/8/67</u>	
22d. ADDRESS <u>BALTIMORE County General Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>(ANSHE EMUNAH) - AITZ CHAIM</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>AUG 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10628  
CERTIFICATE OF DEATH10628  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md. DUNDALK 031</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		d. STREET ADDRESS <u>24 Leeway</u>	
3. NAME OF DECEASED (Type or print) First <u>Sevena</u> Middle <u>D.</u> Last <u>Hicks</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1876</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KENTUCKY</u>	
11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE CARROLL</u>		14. MOTHER'S MAIDEN NAME <u>MURRINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-36-2916</u>	
17. INFORMANT <u>MRS MARY HICKS</u>		Address <u>24 LEGWAY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/8 7/19</u> , 19 <u>67</u> , to <u>8/16</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>67</u> , and that death occurred at <u>8:55</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Sorongon</u>		M.D. <u>3915 Hollins Ferry Rd.</u>	
PHYSICIAN'S NAME (Type) <u>Domingo C. Sorongon, M.D.</u>		BALTIMORE Md. <u>21227</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/18/67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD.</u>		ADDRESS <u>3915 Hollins Ferry Rd.</u>	
24a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
10629														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kingsville</b>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Belair Road</b>					d. STREET ADDRESS <b>Belair Road</b>									
3. NAME OF DECEASED (Type or print) <b>Jacob</b> First <b>Frenk</b> Middle <b>Hildt</b> Last					4. DATE OF DEATH <b>Aug. 22</b> 1967									
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 4, 1894</b>		9. AGE (In years, last birthday) <b>73</b> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <b>Phillip I. Hildt</b>					14. MOTHER'S MAIDEN NAME <b>Sarah E. Emerick</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Mrs. Ruth Williams Hildt</b> Address <b>Same</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes</b>										INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>Aug.</b> , 1967, that (I) (we) last saw the deceased alive on <b>Aug 2, 1967</b> , and that death occurred <b>11 45</b> M, from the causes and on the date stated above.														
22a. SIGNATURE <b>William A. Tyson</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-22-67</b>							
22c. PHYSICIAN'S NAME (Type) <b>Dr. William A. Tyson</b>					22d. ADDRESS <b>Kingsville Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>		23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>								
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>					ADDRESS <b>6500 York Rd, Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

10323

CERTIFICATE OF DEATH

Signature

Investigator

Police Officer

Signature

Investigator

Police Officer

James Frank Hill + A

Jan. 1, 1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10630						10630					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fredrick Huntingtown (Rural)</u>					
c. LENGTH OF STAY IN ID <u>9 days</u>						d. STREET ADDRESS <u>Box 323 Box #135</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med. Center</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>George</u> Last <u>Himmer</u>						4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-28</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Division Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bottled Gas Industry</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Conrad Himmer</u>						14. MOTHER'S MAIDEN NAME <u>HELEN ROSINA HERGET</u>					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-24-0087</u>		17. INFORMANT (with Address) <u>Mrs. Mary Lee Himmer RFD, Box #135 Huntingtown Md. 20639</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> <u>146X</u> DUE TO <u>Aspiration pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Nasopharyngeal Carcinoma</u> DUE TO (c) <u>Carcinoma</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aspiration pneumonia</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>NONE</u> p.m. <u>49</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>67</u> , to <u>8/25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/25</u> 19 <u>67</u> , and that death occurred at <u>120</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>M. ALONZO, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. ALONZO, M.D.</u>						22d. ADDRESS <u>GBMC Bal Ho., Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>						ADDRESS <u>W. Broadway &amp; Williams St</u>		25a. REC'D BY REGISTRAR <u>21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10780

STATE OF TEXAS  
COUNTY OF DALLAS

David George Himmer

MALE

John George Himmer

My Notar Public  
C. B. Himmer

Notar Public

NAME

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

10631

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10631

PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN lb <b>21206</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6102 Springwood Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Prinz HISLEY</b>		4. DATE OF DEATH Month Day Year <b>August 24, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1882</b>
9. AGE (In years lost birthday) <b>84</b> yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Prinz</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Koerner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mrs. Majorie Smith</b>		Address <b>6102 Springwood Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism.</b> DUE TO <b>Carcinoma of ovary with metastasis.</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/13/67</b> , 19 <b>67</b> , to <b>8/24/67</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/13/67</b> , 19 <b>67</b> , and that death occurred at <b>10:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Freidoon Malek, M.D.</b>		22b. DATE SIGNED <b>August 24, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Freidoon Malek, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>8-28-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>John C. Miller Inc</b>		ADDRESS <b>6415 Belair Road-21206</b>	
25. RECEIVED BY REGISTRAR <b>AUG 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10001

STATEMENT OF EARTH

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10632

CERTIFICATE OF DEATH

10632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Thomas Lane</u>		d. STREET ADDRESS <u>St. Thomas Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hoff</u> Last <u>Hoff</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1869</u>
9. AGE (In years for birthday) yrs. <u>98</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Stingler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Winkler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-54-4677</u>	
17. INFORMANT <u>Mrs. Henry Hoff</u>		Address <u>Owings Mills, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> DUE TO (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8</u> , 19 <u>67</u> , to <u>Aug. 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 8</u> , 19 <u>67</u> , and that death occurred at <u>1 P.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Owings Mills, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline &amp; Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10633

CERTIFICATE OF DEATH

10633

1. PLACE OF DEATH a. COUNTY <u>Baltimore, Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>				d. STREET ADDRESS <u>6011 Gwynn Oak Ave.</u> <del>XXXXXXX</del>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>T</u> Last <u>HOGAN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-12-07</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Insurance adjuster Balto Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Hogan</u>				14. MOTHER'S MAIDEN NAME <u>Molly Deveney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Betty M. Hogan - 6011 Gwynn Oak Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Old Coronary in May 66</u> (c) <u>Coronary Insufficiency Continued</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 Min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>8-5</u> , 1967, that (I) (we) last saw the deceased alive on <u>8-4</u> 19 <u>67</u> and that death occurred at <u>10:52 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Thor E. Riffe</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-5-67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>4509 Liberty Heights Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-9-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hghts. Ave.</u>				25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10001

CERTIFICATE OF DEATH

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10634

## CERTIFICATE OF DEATH

10634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>194 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2911 Scherer Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>EDWARD JACOB HOLMES</b>		4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/06</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Holmes</b>		14. MOTHER'S MAIDEN NAME <b>Marie E. Rielender</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>216 09 98 70</b>	
17. INFORMANT <b>Clinical Rcds, VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA WITH METASTASIS</b> TO LYMPH NODES AND SKIN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>Feb. 13</b> , 19 <b>67</b> to <b>Aug. 26</b> , 19 <b>67</b> that (I <input checked="" type="checkbox"/> we) last saw the deceased alive on <b>Aug. 26</b> , 19 <b>67</b> , and that death occurred at <b>2:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Ahmed Kutty</b>		22b. DATE SIGNED <b>8/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>AHMED KUTTY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>CHARLES L. STEVENS FUNERAL HOME 1501 E. Fort St.</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

CHARLES L. STEVENS FUNERAL HOME 1501 E. Fort St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1023

Baltimore

Baltimore

Baltimore

1911 days

Fort Howard

2911 Scherer Avenue

Veterans Administration Hospital

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28

Aug 28

HOMER

JACOB

ARMAND

60

10/13/00

Male White

U.S.A.

Baltimore, Maryland

Text Case

Classified

Marie E. Stalander

Edward Holmes

216 CP 28 TO Clinical Recd. VA Hospital, Fort Howard, Md.

Yes

BROCHOPHONIC CARCINOMA WITH METASTASIS

8 months

TO LIVER NOSES AND SKIN

xxx  
xxx

Aug. 28 07

2:15

Feb. 13

07

Aug. 28

X

8/28/07

VA Hospital, Fort Howard, Md.

ARMAND HUTTY, M.D.

Baltimore, Maryland

John Haven Memorial

Hospital

Baltimore, Md.

CHARLES E. STEVENS MEMORIAL HOSPITAL, Fort St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10635

CERTIFICATE OF DEATH

10635

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN TB <u>21 days</u>		d. STREET ADDRESS <u>3108 Remington Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY MARGARET HOOPER</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/14/18</u>
9. AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR CLOTHING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CLARKSBURG, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Olivero</u>		14. MOTHER'S MAIDEN NAME <u>Theresa OLIVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>235-10-1719</u>	
17. INFORMANT <u>BARBARA J. HAWES</u>		Address <u>4108 FALLS RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydropneumothorax - respiration difficulty.</u> DUE TO (b) <u>Cancer of breast metast. to right humerus</u> DUE TO (c) <u>lungs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a.m. <u>---</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/10/1967</u> , to <u>8/31/1967</u> , that (I) (we) last saw the deceased alive on <u>8/30/1967</u> , and that death occurred at <u>4:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>N. Eftakhari</u>		22b. DATE SIGNED <u>8-31-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Nasser Eftakhari</u>		22d. ADDRESS <u>GBMC 6701 N. Charles St. Balto. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Balto National</u>	23d. LOCATION (City or Town) (County) (State) <u>Fredrick Rd. ind.</u>
24. FUNERAL DIRECTOR <u>Austin E. Donovan</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>	
ADDRESS <u>3818 Roland Ave</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles J. J.</u>	

NOTICE: THIS REPORT IS OF A PRELIMINARY NATURE AND IS NOT TO BE USED FOR OFFICIAL PURPOSES.

STATEMENT OF WORK

10033

1. PURPOSE

2. SCOPE

3. OBJECTIVES

4. METHODOLOGY

5. RESULTS

6. CONCLUSIONS

7. RECOMMENDATIONS

8. REFERENCES

9. APPENDICES

10. GLOSSARY

11. INDEX

12. DISTRIBUTION

13. APPROVALS

14. SIGNATURES

15. DATE

16. PAGE

17. TOTAL PAGES

18. TOTAL WORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
8  
10636  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
10636

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN 1b <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 396 - Rt. 15 - Balto., Md. 20</u>		d. STREET ADDRESS <u>Box 396 - Rt. 15.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE - HORNER</u>		4. DATE OF DEATH Month Day Year <u>8-21-1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>MAX SCHRECK</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE MUTH.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>22022 9896A</u>	
17. INFORMANT <u>Mr. Wm. C. Homer - Box 396 Rt. 15 Balto. 20</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Art. sclerotic cerebrovascular disease</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1964</u> to <u>Aug 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 21, 1967</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis Semenovoff</u>		22b. DATE SIGNED <u>8/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOVFF</u>		22d. ADDRESS <u>2108 OREMUS RD, BALTO. MD. 21220</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. Mo.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Antley Miller - 2334 Jefferson St.</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

10030

1. Name of deceased John Doe  
2. Sex Male  
3. Age 45  
4. Date of birth Jan 15 1925  
5. Date of death Dec 10 1970  
6. Place of death Home  
7. Cause of death Heart disease  
8. Signature of physician Dr. J. K. Smith  
9. Signature of registrar John Doe  
10. Date of registration Dec 15 1970



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10637		CERTIFICATE OF DEATH	
10637		10637	
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>56 days</b>		d. STREET ADDRESS <b>211 Wickham Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD HILBERT HYLAND</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1904</b>
9. AGE (In years lost birthday) yrs. <b>63</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Maurice Hyland</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McLaughlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Pl-28</b>		16. SOCIAL SECURITY NO. <b>218 14 54 13</b>	
17. INFORMANT <b>Clinical Rcds. VA Hospital, Fort Howard, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC PULMONARY EMPHYSEMA</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 16, 19 67</b> , to <b>Aug 11, 19 67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 11, 19 67</b> , and that death occurred at <b>5.20 P.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Deogracias V. Faustino, M.D.</b>		22b. DATE SIGNED <b>8/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DEOGRACIAS V. FAUSTINO, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>MacKabb Funeral Home Fred. and Wade A.C. Balto Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10033

Bellevue

Bellevue

Fort Howard

Fort Howard

Fort Howard

Veterans Administration Hospital

Veterans Administration Hospital

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Aug. 14

Aug. 14

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Aug. 14

Fort Howard, M.D. VA Hospital, Fort Howard, M.D.

Fort Howard

Fort Howard

Fort Howard

Fort Howard, M.D. VA Hospital, Fort Howard, M.D.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10638

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10638

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>Hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>30 Main Street</b>		e. STREET ADDRESS <b>213 Main Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOAN MAS INGLE</b>		4. DATE OF DEATH Month Day Year <b>August 17, 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-34</b>
9. AGE (In years last birthday) yrs. <b>32</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gordon A. Sutton</b>		14. MOTHER'S MAIDEN NAME <b>Cleo Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-3958</b>	
17. INFORMANT <b>Mr. Gordon A. Sutton</b>		Address <b>5926 Falls Rd. 21209</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic insufficiency with massive left ventricular hypertrophy and dilatation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>XXXXX</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED <b>August 17, 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/19/67/</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Clynmalira Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore County Md.</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 24 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

10639

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10639

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>Box 284 Manor Road</b>			
3. NAME OF DECEASED (Type or print) <b>OSCAR L. Isennock Jr.</b>				4. DATE OF DEATH <b>August 22 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/12/1933</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Oscar L. Isennock Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Bertha M. Unkart</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Mr. Oscar L. Isennock Sr.</b> Address <b>same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fatty liver</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Park Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>				25a. RECD. BY REGISTRAR <b>AUG 24 1967</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10640					10640						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Baltimore</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Knoxville</u>						
c. LENGTH OF STAY IN 1b <u>6 Months</u>					d. STREET ADDRESS <u>Rt. I. Box 141</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First <u>Wayne</u> Middle <u>Edward</u> Last <u>Jackson</u>					Month <u>8</u> Day <u>12</u> Year <u>1967</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-65</u>		9. AGE (in years last birthday) <u>2</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Edward Jackson</u>					14. MOTHER'S MAIDEN NAME <u>Catherine E. Spriggs</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Meningitis</u> 3441 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hydrocephalus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>26 mos.</u>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that <u>NO</u> (this hospital) attended the deceased from <u>1-24</u> , 19 <u>67</u> , to <u>8-12</u> , 19 <u>67</u> , that <u>OK</u> (we) last saw the deceased alive on <u>8-7-67</u> , 19 <u>67</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard A. Jones</u>					22b. DATE SIGNED <u>8-14-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones, M.D.</u>				
22d. ADDRESS <u>Rosewood St. Hosp., Owings Mills, Md.</u>					22e. REC'D BY REGISTRAR <u>Charles Judge</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>8/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) <u>Petersville Md.</u>		
24. FUNERAL DIRECTOR <u>Feete Funeral Home</u>					ADDRESS <u>Brunswick, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10000

CENTRAL

UNITED STATES DEPARTMENT OF AGRICULTURE

1914

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1913

AND THE PROCEEDINGS OF THE BOARD OF LAND COMMISSIONERS

IN THE YEAR 1913

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AND THE PROCEEDINGS OF THE BOARD OF LAND COMMISSIONERS

IN THE YEAR 1913

FOR STATE  
HEALTH DEPT.

10641

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10641

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN lb <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>208 Riverview Ave.</b>		d. STREET ADDRESS <b>208 Riverview Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Leo</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1908</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edward Janowitz</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-03-2082</b>	
17. INFORMANT <b>Mrs. Madeline Janowitz</b>		Address <b>208 Riverview Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Alcoholism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theodore C. Patterson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Theodore C. Patterson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>105 Main, Dundalk, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City or Town) (County) (State) <b>Overlea, Md.</b>	
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 11 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
10642		CERTIFICATE OF DEATH		10642	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>BALTIMORE</b> MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>50 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>3704 GARRISON BLVD.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES STEWART JENKINS</b>			4. DATE OF DEATH Month Day Year <b>AUGUST 3 19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/97</b>		9. AGE (In years last birthday) yrs. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LONG SHOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LONG SHOREMAN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond County VA.</b>	
13. FATHER'S NAME <b>DECEASED FLEET JENKINS</b>			14. MOTHER'S MAIDEN NAME <b>ROSE FISHER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>217 09 94 22</b>		17. INFORMANT <b>VAH RECORDS FORT HOWARD, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5810 ACUTE GASTRIC DILATATION WITH PERFORATION</b>					INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CIRRHOSIS, LIVER BRONCHOPNEUMONIA</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE 14</b> , 19 <b>67</b> , to <b>AUGUST 3</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>AUGUST 3</b> , 19 <b>67</b> , and that death occurred at <b>10:45 AM</b> from causes on and on the date stated above.					
22a. SIGNATURE <i>John D. Talbert</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/4/67</b>
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>			22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MORTON AND DYETT</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Francis Judge</i>

10000

RECEIVED  
JANUARY 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: JAMES EARL RAY; AKA; C-100-100000

RE: NEW YORK TELETYPE TO BUREAU, JANUARY 9, 1964.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE MATTER:

ON JANUARY 8, 1964, AN INDIVIDUAL IDENTIFIED HIMSELF AS JAMES EARL RAY, AKA, AND STATED THAT HE WAS CURRENTLY IN THE NEW YORK AREA.

THE INDIVIDUAL STATED THAT HE HAD BEEN IN CONTACT WITH AN INDIVIDUAL WHO WAS CURRENTLY IN THE NEW YORK AREA, AND THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL WAS CURRENTLY IN THE NEW YORK AREA.

THE INDIVIDUAL STATED THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL WAS CURRENTLY IN THE NEW YORK AREA, AND THAT HE HAD BEEN ADVISED THAT THE INDIVIDUAL WAS CURRENTLY IN THE NEW YORK AREA.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10643						10643					
1. PLACE OF DEATH a. COUNTY <u>Baltimore, Md</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u></u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				30-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>						d. STREET ADDRESS <u>4301 Roland Ave.,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa R</u> Middle <u>Jessa</u> Last <u></u>						4. DATE OF DEATH Month <u>8/6/67</u> Day <u>19</u> Year <u>19</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/9/ 1873</u>		9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bavaria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Franz Joseph Ruff</u>						14. MOTHER'S MAIDEN NAME <u>Maria Augusta Reinhard</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-18-2516</u>		17. INFORMANT <u>Hospice records</u> Address <u></u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>1. Intestinal Obstruction</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>2. Perforated Ca Colon</u> DUE TO (c) <u>3. Sepsis</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28/66</u> , 19 <u>66</u> , to <u>8/6/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/11/67</u> , 19 <u>67</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert J. Mahon</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>8/6/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u>						22d. ADDRESS <u>204 E. Joppa Rd., Towson</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>8-10-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Anne Arundel Md.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>C.F. EVANS &amp; SON 8802 Harford road</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10643

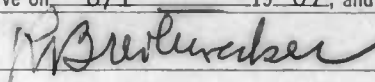
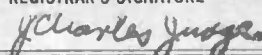
STATE OF TEXAS

C. J.

C. F. EVANS & SON 8802 Harford Road  
Burlington 8-10-67 Holy Cross Cem.  
Anne Arundel Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore Co.</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1207 Nolan Court Balto., Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED (Type or print)</b> First <b>(New Born Baby) Vanessa</b> Middle <b>Jones</b> Last <b>Jones</b>					<b>4. DATE OF DEATH</b> Month <b>8</b> Day <b>1</b> Year <b>19 67</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>C</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>7/31/67</b>		<b>9. AGE (In years last birthday)</b> <b>0 yrs.</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>-</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Baltimore Co., Md.</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Kelvin NMN Hankerson</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Carolyn Jones</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-</b>		<b>17. INFORMANT</b> <b>Mother's Chart</b>			<b>Address</b> <b>Same</b>		
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory distress</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration pneumonia</b> DUE TO (c)									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>29 hrs. 51 m</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>7/31</u>, 19 <u>67</u>, to <u>8/1</u>, 19 <u>67</u>, that (I) (we) last saw the deceased alive on <u>8/1</u>, 19 <u>67</u>, and that death occurred at <u>10:10</u> a.m., from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> 					<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8/1/67</b>		
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>R. Breiteneker, M.D.</b>					<b>22d. ADDRESS</b> <b>6701 N. Charles Street</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8/4/67</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Calvary Cem.</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Anne Arundel Cty. Md.</b>			
<b>24. FUNERAL DIRECTOR</b> <b>Wm. C. March 928 E. North Ave.</b>					<b>25a. REC'D BY REGISTRAR</b> <b>AUG 7 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 		

10044

*Handwritten signature*

W. C. M. 2 2545 N. W. 111  
AUG 7 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10645

CERTIFICATE OF DEATH

10645

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Earl C. Jordan</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1906</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor St. of Md. Dept. Emp. Sec.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George T. Jordan</b>		14. MOTHER'S MAIDEN NAME <b>Sadie B. Geyer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>213-01-5394</b>	
17. INFORMANT <b>Mrs. Jo Ann Jordan</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Myocardial Infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/2/67</b> , 19 <b>67</b> , to <b>8/12/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/2/67</b> , 19 <b>67</b> , and that death occurred at <b>6</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John R. Davis</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Russell Davis</b>		22d. ADDRESS <b>Medical Arts Bldg.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/12/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 11 1967</b>	
ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
10646 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10646													
Item # 3 411m # 3392 9/22/67 ph													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b> c. LENGTH OF STAY IN 1b <b>30-4</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Plant Dispensary</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>4536 Shamrock Ave #6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Edwin Edmund Raymond Kantorski</b> First <b>John</b> Middle <b>Kantorski</b> Last <b>Kantorski</b>						4. DATE OF DEATH <b>8</b> Month <b>2</b> Day <b>1967</b> Year							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/22/14</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman (Railroad)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Makin</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>John Kantorski</b>						14. MOTHER'S MAIDEN NAME <b>unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>216-01-9747</b>		17. INFORMANT Address <b>Alvina Wolf Kantorski, wife, above</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Coronary Occlusion</b> <b>4201</b> IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>N</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>N</b>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>M. B. Davis</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D. 6800 Morningside Rd. Dundalk, Md. 21222</b>						22. DATE SIGNED <b>8-2-67</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>8/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>Schimmunek Funeral Home, Inc. 3331 Brehms Lane</b>						25a. REC'D BY REGISTRAR <b>AUG 4 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10647

CERTIFICATE OF DEATH

10647

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			d. STREET ADDRESS <b>1919 Armco Way #21222</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Caroline J. Keller</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>August 8 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1915</b>		9. AGE (In years lost birthday) <b>51</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Albert F. Goetzke &amp; Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Anton Runge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-0461</b>		17. INFORMANT Address <b>Albert C. Keller, husband, above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1992</b> IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August 7, 1967</b> , to <b>August 8, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 8, 1967</b> , and that death occurred at <b>1:10 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Jaime Ambrad</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 8, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Jaime Ambrad, M.D.</b>			22d. ADDRESS <b>7620 York Road #21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home</b> <b>3331 Brehms Lane #13</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

UNITED STATES OF AMERICA

Department of Justice

Washington, D.C.

Office of the Director of the Bureau of Prisons

Washington, D.C. 20535

Enclosed for the Bureau of Prisons are

two copies of the report of the

Commission on the Organization and

Administration of the Federal Prison

System, dated June 1, 1964.

The report is being furnished to you

for your information and for the

information of the Bureau of Prisons.

Very truly yours,

Director, Bureau of Prisons

Enclosure

cc: Bureau of Prisons

cc: Bureau of Prisons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10648  
CERTIFICATE OF DEATH  
10648

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>MICHAEL</b> Last <b>Keller</b>				4. DATE OF DEATH Month <b>8/</b> Day <b>19</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 1, 1884</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>19</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VET VETERINARY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FREDERICK KELLER</b>				14. MOTHER'S MAIDEN NAME <b>GEORGIA DIETZ</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES W.W.I</b>				16. SOCIAL SECURITY NO. <b>213-40-0057</b>		17. INFORMANT <b>Patient's Chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> , 1967, to <b>8/19</b> , 1967, that (I) (we) last saw the deceased alive on <b>8/19</b> , 1967, and that death occurred at <b>8:30 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John E. Adams</b>				22b. DATE SIGNED <b>8/19/67</b>		22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>	
22d. ADDRESS <b>6701 N. Charles Street</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <b>Aug. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pikesville</b>	
23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>							
24. FUNERAL DIRECTOR <b>Frank H. Newell</b>				25a. REC'D BY REGISTRAR <b>AUG 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10613

General and Special Historical Society

Frank

1913-1914

1913-1914



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10649

CERTIFICATE OF DEATH

10649

1. PLACE OF DEATH a. COUNTY <u>BMC - Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN Ib <u>8 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>				d. STREET ADDRESS <u>536 West University Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Virginia</u> Middle <u>Kelley</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-07</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN FRANCIS KELLEY</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Morgan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>213-10-9312</u>		17. INFORMANT <u>Admission SHEET</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carotid failure,</u> DUE TO <u>Carcinoma Uterin &amp; metastatic disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 July, 1967</u> , to <u>15 July, 1967</u> , that (I) (we) saw the deceased alive on <u>14 July 1967</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Duncan McGhie</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>15 Aug 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DUNCAN MCGHIE</u>				22d. ADDRESS <u>5645 LOTUIAN Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery Woodlawn Balto., Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u> ADDRESS <u>21212 4905 York Rd. Balto., Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 16 1967</u>							

10849

STATE OF OHIO

IN SENATE, January 10, 1901.

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE  
FOR THE YEAR  
1900.

ALBION, OHIO,  
JANUARY 10, 1901.

WILLIAM H. HARRIS,  
GOVERNOR.

JOHN W. WATSON,  
COMMISSIONER.

25 Cent Edition.

Printed by the  
State of Ohio,  
1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>38 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3440 Chestnut Avenue</u> d. STREET ADDRESS <u>3440 Chestnut Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARMEN BLANCHE KELLY</u> First Middle Last		4. DATE OF DEATH <u>8/18/67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/94</u> 9. AGE (In years last birthday) <u>73</u> IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, foreign country) <u>W. INDIES-T. S. L. OF S. KIT</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PERCY TODD</u>		14. MOTHER'S MAIDEN NAME <u>LAURA PEDDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>069-07-8196</u>	
17. INFORMANT <u>PATIENT CHART</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of inferior vena cava</u> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic renal disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic asthma 70 years, Mild emphysema,</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>4020 conv</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>67</u> , to <u>8/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>67</u> , and that death occurred at <u>840M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Deveh A Bruce</u>		22b. DATE SIGNED <u>8/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEVEH A. BRUCE</u>		22d. ADDRESS <u>J. B. M. C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-21-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Md.</u>	
24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 21 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10840

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10651

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX - 21</b>		c. LENGTH OF STAY IN 1b <b>ESSEX - 03-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROCKAWAY BEACH</b>		d. STREET ADDRESS <b>605 N. STUART</b>	
3. NAME OF DECEASED (Type or print) <b>THERESA KELLY</b>		4. DATE OF DEATH Month <b>8</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/59</b>
9. AGE (In years last birthday) yrs. <b>8</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS KELLY SR.</b>		14. MOTHER'S MAIDEN NAME <b>SALLY NOONAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>THOMAS KELLY</b>		Address <b>ABOVE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 9298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped while in picnic</b>	
20c. TIME OF INJURY Month, Day, Year <b>130</b> Hour <b>8-19</b> p.m. <b>1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Middle River</b>		20f. (City or town) (County) (State) <b>Essex-21 Balto Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D.	
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		22. DATE SIGNED <b>8/23/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>J.S. CONNELLY SONS</b>		25a. REC'D BY REGISTRAR <b>300 MACE</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 25 1967</b>	

1030

DATE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

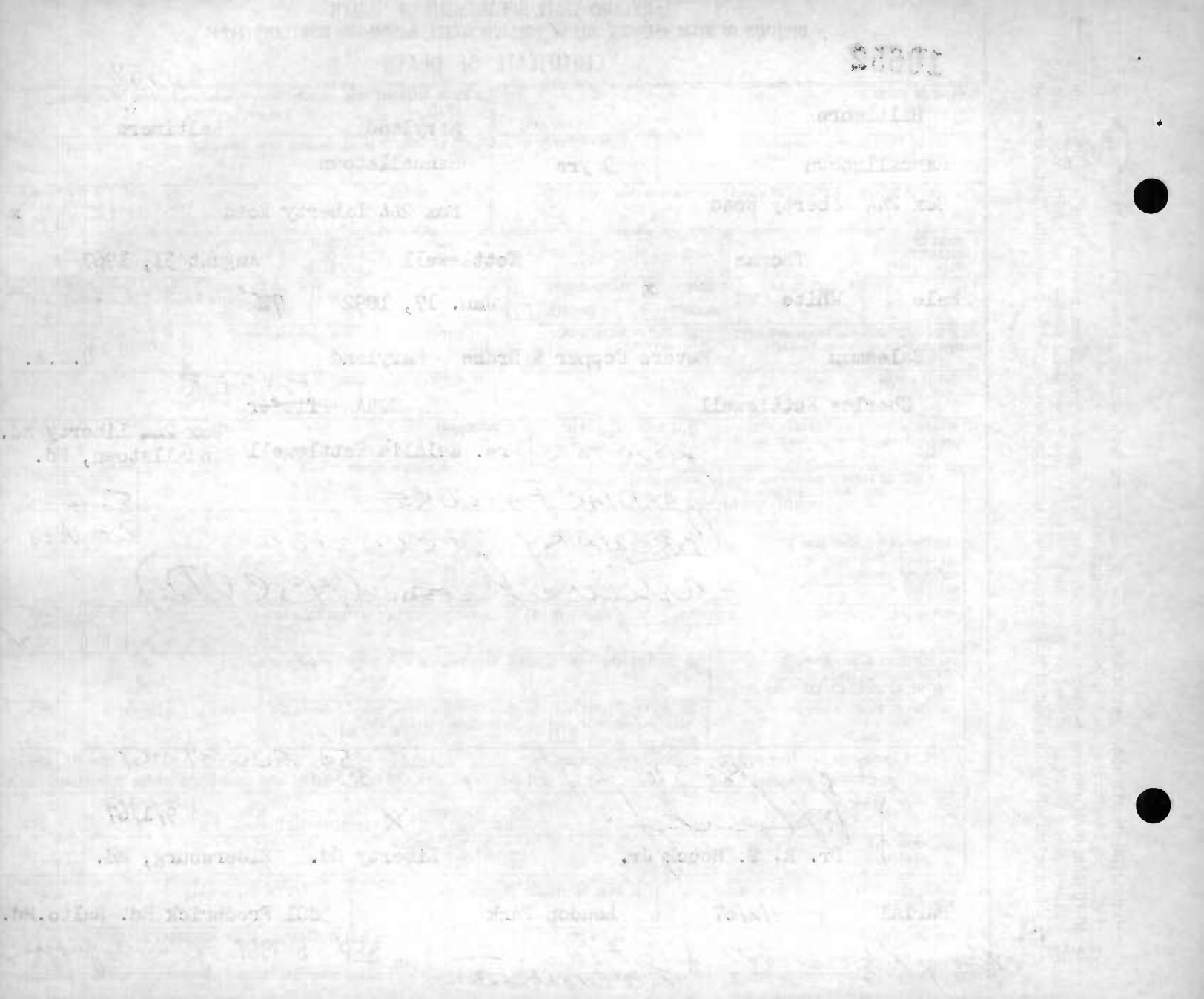
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10652

CERTIFICATE OF DEATH

10652

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY IN 1b <b>19 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 244 Liberty Road</b>		d. STREET ADDRESS <b>Box 244 Liberty Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Kettlewell</b> Last <b>Kettlewell</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1892</b>
9. AGE (In years, last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>7</b> Days <b>15</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Revere Copper &amp; Brass Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Kettlewell</b>		14. MOTHER'S MAIDEN NAME <b>PYFER CORA Pfeifer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-10-9875</b>	
17. INFORMANT <b>Mrs. Eulalia Kettlewell</b>		18. ADDRESS <b>Box 244 Liberty Rd. Randallstown, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> DUE TO (b) <b>CORONARY OCCLUSION</b> DUE TO (c) <b>arteriosclerosis (ASCVD)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4201</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>AUG 31, 1967</b> , that (I) (we) last saw the deceased alive on <b>8-31-67</b> , and that death occurred at <b>3:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. R. V. Houck Jr.</b>		22b. DATE SIGNED <b>9/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. V. Houck Jr.</b>		22d. ADDRESS <b>Liberty Rd. Eldersburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	23d. LOCATION (City or Town) (County) (State) <b>3801 Frederick Rd. Balto. Md.</b>
24. FUNERAL DIRECTOR <b>Spring Byers</b>		25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>8728 Liberty Rd. Randallstown</b>	



10653

## CERTIFICATE OF DEATH

10653

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY in lb <b>56 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - 21215</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>3728 PARK HEIGHTS AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>JOSEPH</b> Last <b>KIGGINS, JR.</b>			4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/7/07</b>	9. AGE (In years last birthday) yrs. <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>PHILADELPHIA, PA.</b>	
13. FATHER'S NAME <b>JAMES KIGGINS</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>226 03 06 58</b>		17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>HYPERTENSION</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>10 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC BRONCHITIS</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>6/15/67</b> , 19__ to <b>8/10/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>8/10/67</b> , 19__, and that death occurred at <b>4:05 P.M.</b> on causes and on the date stated above.					
22a. SIGNATURE <i>Jorge A. Fabara</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/10/67</b>
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>			22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Leonard J. RUCK FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>AUG 11 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10654

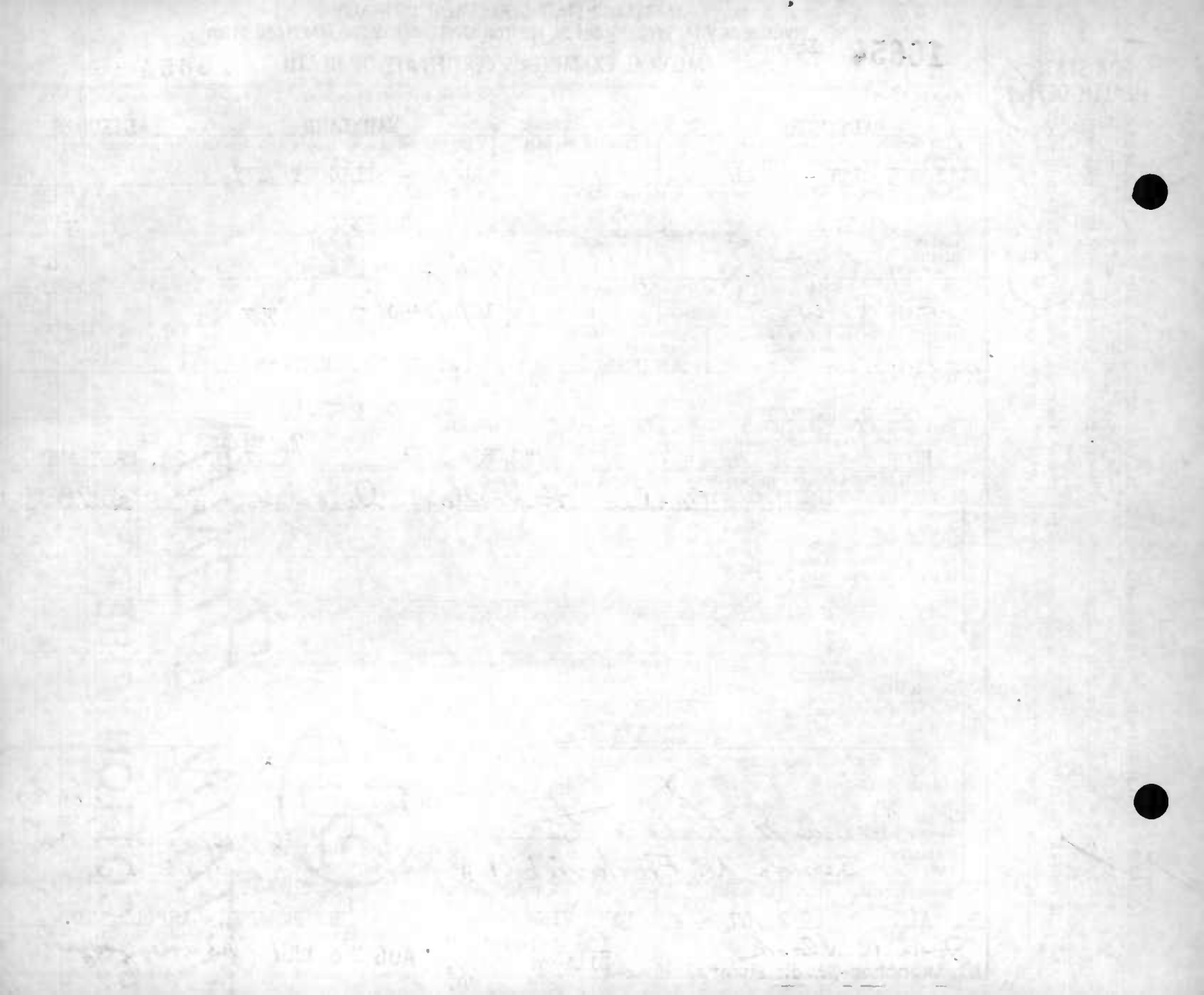
10654

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY - RURAL</b>		c. LENGTH OF STAY IN 1b <b>ROUTE 4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE 4</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eva</b>		4. DATE OF DEATH Month <b>8</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1890</b> 1889 <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>JOHN H. PARRISH</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>GLORIA BELL</b>		Address <b>7 WINTERS LANE BALTIMORE 28, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular Disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James N. Frederick</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James N. Frederick MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1311 Francis Ave</b>	
		Address (Street, city, town, or county) <b>Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LAKE VIEW</b>	23d. LOCATION (City or Town) (County) (State) <b>ELDERSBURG, CARROLL, MD.</b>
24. FUNERAL DIRECTOR <b>John R. Slack</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>	
Address <b>Highbotham-Slack Funeral Home</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10655 CERTIFICATE OF DEATH 10656

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 21214</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Towson Convalescent Home</b>		d. STREET ADDRESS <b>1529 E. Coldspring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD C. KNOX</b>		4. DATE OF DEATH Month Day Year <b>August 28, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>guard-U.S.Gov't.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Edward F. Knox</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-01-6213</b>		17. INFORMANT Address <b>Mrs Mary V. Knox 1529 E. Coldspring Lane</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X Carcinoma Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Metastases to lungs &amp; liver</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 26, 1967</b> to <b>Aug 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>8/28, 1967</b> , and that death occurred at <b>7:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Laurence Post</b>		22b. DATE SIGNED <b>Aug 28, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Laurence Post, M.D.</b>		22d. ADDRESS <b>6805 York Rd. Baltimore</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/31/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>
23d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H. Sander &amp; Sons, Inc., Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

10322

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Town

Town Government

Edward

Knock

John W. White

Jan. 2, 1888

Edward W. Gov. Resided

Canada

Edward W. Knox

Unknown

220-01-0215

no

John W. White

6805 York Rd. Baltimore

Lawrence Ford, N.P.

Baltimore Secretary

Journal 8/1/67

N. Bender & Sons, Inc., Baltimore, Md.

10656

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10657

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5900 Southwestern Blvd.</b>		d. STREET ADDRESS <b>5900 Southwestern Blvd.</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM IRVIN KOCH</b>		4. DATE OF DEATH <b>August 6 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/2/95</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) <b>Retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Pumper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>- - Koch</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>7/25/47-7/5/47</b>	
16. SOCIAL SECURITY NO. <b>215-12-8463A</b>		17. INFORMANT <b>Mrs. Nora A. Koch, 1458 Battery Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.		22. DATE SIGNED <b>August 7, 1967</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR <b>AUG 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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10658

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sheppard- Enoch Pratt Hospital</b>		d. STREET ADDRESS <b>2212 N. Trinidad Street</b>	
3. NAME OF DECEASED (Type or print) <b>Delores Eveleen KOENIG</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/24/37</b>
9. AGE (In years birthday) yrs. <b>30</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Victor Eby</b>		14. MOTHER'S MAIDEN NAME <b>Annabelle Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>264-52-0526</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>974X</b> IMMEDIATE CAUSE (a) <b>Hanging Causing</b> DUE TO <b>Suffocation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia Paranoid Type</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Hanging from Closet by Belt</b>	
20c. TIME OF INJURY Month, Day, Year <b>8/19/67</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Hospital - Mental Illness</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>8-24-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cem.</b>		23d. LOCATION (City or town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25a. REC'D BY REGISTRAR <b>DAUG 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22. DATE SIGNED <b>8/19/67</b>	

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TO HOSPITAL  
death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10658

10659

1. PLACE OF DEATH a. COUNTY <u>Balto</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u></u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Final Balto</u>		c. LENGTH OF STAY IN 1b <u>10 mo</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>515 S. Glover St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St Joseph Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First <u>KOZUBSKI</u> Middle <u></u> Last <u></u>				DATE OF DEATH <u>AUG 16</u> 19 <u>67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1870 OCT 16</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Stanley Choma</u>				14. MOTHER'S MAIDEN NAME <u>ROZAK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>WANDA PANIOWICZ</u>		Address <u>8614 OAK RD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>7824</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>			
20c. TIME OF INJURY Hour <u></u> e.m. <u></u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1967</u> to <u>15 Aug 1967</u> , that (I) (we) last saw the deceased alive on <u>15 Aug 1967</u> , and that death occurred at <u>12:45</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>William Goodman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>16 Aug 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>133 S. SORPARK SPRING RD.</u>				22d. ADDRESS <u>133 S. SORPARK SPRING RD 4227</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>DUNDALK MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Nefer</u>				ADDRESS <u>JOHN M. WEBER SON INC</u> <u>FUNERAL HOME</u> <u>401. S. CHESTER ST</u>		25a. REC'D BY REGISTRAR <u>AUG 18 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

10055

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*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10659

CERTIFICATE OF DEATH

10660

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN Tb <b>2 YEARS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 7, Maryland</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>2809 Silver Hill Road Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Jerome</b> Middle <b>J.</b> Last <b>Krein</b>		4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-83</b>
9. AGE (In years l birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORES</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank</b>		14. MOTHER'S MAIDEN NAME <b>Annie HUBER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>215-03-2551</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Generalized Arteriosclerosis, severe</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Several decubital ulcers (buttocks, both heels)</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>none</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-22</b> , 19 <b>65</b> , to <b>8-6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>August 6</b> , 1967, and that death occurred at <b>2:30A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Imre KOPITS, M.D. (K-7077)</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/ 9/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery Woodlawn, Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		25a. REC'D BY REGISTRAR <b>Glen Burnie, Md. 21061</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		DATE <b>AUG 8 1967</b>	

10352

Baltimore

Uptonville

Spring Grove State Hospital

Baltimore, Maryland

2809 Silver Hill Road

Kevin

John

White

Male

12-22-23

Maryland

Baltimore

Frank

Anna H. H. H.

Records: Spring Grove State Hospital

215-03-2251

Unknown

Acute Heart Failure

Generalized arteriosclerosis; severe  
arteriosclerotic heart disease

Severe decubital ulcers (bilateral, both heels)

None

10-22

2:30

*John H. H. H.*

Spring Grove State Hospital  
Baltimore, Maryland 21201

John H. H. H. (1-1-1977)

8/10/67

Local

1-1-1977

Unknown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10660

CERTIFICATE OF DEATH

10661

1. PLACE OF DEATH a. COUNTY <b>TOWSON - BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE TOWSON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL TOWSON</b>		c. LENGTH OF STAY IN 1b <b>34 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON - HAMPTON</b>		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>		d. STREET ADDRESS <b>1300 WOODSHOLE ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MILFORD FISKE LACKEY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAU</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/26/1904</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PERSONNEL OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ST. OF Md. HYGIENE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>OACAR FRANCIS LACKEY</b>		14. MOTHER'S MAIDEN NAME <b>MARYMYER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>215-03-9443</b>	
17. INFORMANT <b>MRS. SUSANNA M. LACKEY (SAME)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4200 IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b> DUE TO (b) <b>Cerebro-vascular accident.</b> DUE TO (c) <b>arteriosclerotic &amp; hypertensive heart disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/3</b> , 19 <b>67</b> , to <b>8/5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> , 19 <b>67</b> , and that death occurred at <b>8:23 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Derth A Bruce</b>		22b. DATE SIGNED <b>8/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Derth A. Bruce, M. D.</b>		22d. ADDRESS <b>Greater Balto. Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/9/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

10001

UNIVERSITY OF CALIFORNIA

STATE OF CALIFORNIA - DEPARTMENT OF HEALTH

NAME: CAN  
MARRIED: YES  
BIRTH: 6/20/1904  
BIRTHPLACE: BATHURST, NEW HAMPSHIRE  
CIVIL STATUS: SINGLE  
MILITARY SERVICE: NONE  
EDUCATION: HIGH SCHOOL  
OCCUPATION: LABORER  
REASON FOR ENTRY: VISITING  
DATE OF ENTRY: 10/1/54  
PORT OF ENTRY: LOS ANGELES  
AGENCY: U.S. CUSTOMS AND BORDER PROTECTION

212-03-748

ENTER - VOUCHER - CANCELLED  
REASON - VOUCHER - CANCELLED

OFFICE OF THE ATTORNEY GENERAL

RECEIVED: 10/1/54

FILED: 10/1/54



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 M  
20 M 1/66

10661

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #12 Film #G392 9/5/67 bh  
10662  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kingsville, 21087</b>		23.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>Rt. 1, Box 347 - Chapman Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Alfred LAHOURATATE</b>				4. DATE OF DEATH Month Day Year <b>8 27 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>6-24-1891</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>France</b>	
13. FATHER'S NAME <b>Basil Lahouratate</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Bernadou</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-5449</b>		17. INFORMANT Address <b>Mrs Marie Rawl Chapman Raod Kingsville, Md. 21087</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>advanced emphysema</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>August 25, 19 67</b> , to <b>August 27 19 67</b> , that <b>1</b> (we) last saw the deceased alive on <b>August 27 19 67</b> , and that death occurred at <b>6:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>				22b. DATE SIGNED <b>August 27, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>	
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-30-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bradshaw, Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 4401 Belair Road</b>				25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

32201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
10662					CERTIFICATE OF DEATH					10663					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>Sussex</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millford</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>					d. STREET ADDRESS <b>204 Lovers Lane</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>John Joseph Lancaster</b>					4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1967</b>										
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 3, 1901</b>		9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Sales &amp; Service</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Media, Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Thomas Robert Lancaster</b>					14. MOTHER'S MAIDEN NAME <b>Sara Elizabeth Evans</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216 09 3962</b>		17. INFORMANT Address <b>Mrs. Joseph Bremer, Baltimore, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio pulmonary Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pulmonary Infarction, Multiple</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 8th</b> , 1967, to <b>August 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 17 19 67</b> , and that death occurred at <b>1:30 A.M.</b> from causes and on the date stated above.															
22a. SIGNATURE <i>Jaime Singzon</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-17-67</b>							
22c. PHYSICIAN'S NAME (Type) <b>Jaime Singzon, M.D.</b>						22d. ADDRESS <b>7620 York Rd., Towson 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/20/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>					
24. FUNERAL DIRECTOR <b>Wm A. Berry Jr Millard Del</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 22 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Jaime Singzon</i>							

10088

20088

200 Lovers Lane

USA

John Elizabeth Evans

Thomas Robert Lancaster

210 09 300000, Joseph Bremer, Baltimore, Md.

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Chesapeake Cemetery

Chesapeake Cemetery

8/20/67

Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
10664									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN lb <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 21204</u>				
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>1201 Doves Cove Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Edward</u> Last <u>Lehr</u>					4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-97</u>		9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Balto., Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. Lehr</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Orttman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>WW-I and II</u>			16. SOCIAL SECURITY NO. <u>214-40-2665</u>		17. INFORMANT <u>patient's chart.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Liver Metastasis to metastasis</u> (c) <u>to metastasis?</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> not work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>67</u> to <u>8-4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-4</u> , 19 <u>67</u> and that death occurred at <u>9:12 AM</u> , from causes and on the date stated above.									
22a. SIGNATURE <u>Jose M. de Leon, MD</u>					22b. DATE SIGNED <u>8-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>Aug. 5. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematorium</u>			23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>HENRY SANDER &amp; SONS, INC.</u>					25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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RECEIVED OF DEATH

RECEIVED FROM JULY 1967

RECEIVED FROM JULY 1967



Item 8 Film G392 8/21/67 kdk  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

10664

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>16</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21234</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>9850 Harford Rd.</b>					
3. NAME OF DECEASED (Type or print) <b>Annie Crawford Lisle</b>		4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1967</b>							
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1882</b>	9. AGE (In years lost birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John D. Lisle</b>		14. MOTHER'S MAIDEN NAME <b>Annie Crawford</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-46-8109</b>		17. INFORMANT <b>Mr. Robert D. Lisle</b>		Address <b>Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>9040</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure Following</b> DUE TO <b>16 Days</b> (b) <b>Bronchial pneumonia</b> DUE TO <b>16 Days</b> (c) <b>Fractured left Hip</b> DUE TO <b>6 wks</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in own Home</b>		20c. TIME OF INJURY Month, Day, Year <b>1300 p.m. July 5, 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) (County) (State) <b>Parkville Baltimore Md</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>8/16/67</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 19, 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Reisterstown, Md.</b>			
24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>807 Wood Glen Place</u>	
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First <u>Liss</u> Middle Last		4. DATE OF DEATH <u>August 31</u> Month <u>19</u> Day <u>67</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>Bank</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. Gustave Liss, 6203 Lincoln Avenue #9</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> DUE TO <u>myth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myth</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1933</u> , 19 <u>67</u> to <u>9/31</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/29</u> 19 <u>67</u> and that death occurred at <u>10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Milton Kirsh</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Milton Kirsh</u>		22d. ADDRESS <u>4000 W. Northern Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Har Zion Tifereth Israel</u>	23d. LOCATION (City or Town) (County) (State) <u>Rosedale, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. RECEIVED BY REGISTRAR <u>SEP 6 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Rt. 26 Randallstown, 3 Weeks</u>				c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Randallstown - Chapel Hill Nursing Home</u>				d. STREET ADDRESS <u>Bollinger Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Louch</u> Last <u>Louch</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1885</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chegoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Joseph Louch</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS. Caroline Louch - Finksburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach, Liver metastasis,</u> <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Lung metastasis, Bronchial pneumonia,</u> DUE TO (c) <u>G. I. obstruction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>May 5, 1967 through Aug. 11, 1967</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 5,</u> 19 <u>67</u> , to <u>Aug. 11,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 11,</u> 19 <u>67</u> , and that death occurred at <u>4P.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug. 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md.</u>				25a. REC'D BY REGISTRAR <u>AUG 16 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10667

10668

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN IS <b>18 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b># 340 NEWKIRK STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>NICHOLAS</b> Middle <b>-</b> Last <b>LOULUDIS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/15/15</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. EATHER'S NAME <b>GEORGE LOULUDIS</b>		14. MOTHER'S MAIDEN NAME <b>SYLVIA POLETIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>072 05 86 06</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>ARTERIOIAL NEPHROSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>WEEKS</b> <b>YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>8/2/67</b> , 19__, to <b>8/20/67</b> , 19__, that <b>he</b> (we) last saw the deceased alive on <b>8/20/67</b> , 19__, and that death occurred at <b>11:15 PM</b> on <b>8/20/67</b> from causes and on the date stated above.			
22a. SIGNATURE <b>JOHN D. TALBERT</b>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Joseph N. Zannino Jr.</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John D. Talbert</b>		25c. ADDRESS <b>257 S. CONKLING ST. BALTIMORE, MD.</b>	

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UNITED STATES

DEPARTMENT OF JUSTICE

ATTORNEY GENERAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #10 Film #391 8/11/67 PH

CERTIFICATE OF DEATH

10668

10669

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2903 Hiss Avenue</b>		d. STREET ADDRESS <b>2903 Hiss Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>A.</b> Last <b>LUBY</b>		4. DATE OF DEATH Month <b>August 1,</b> Day <b>1967.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 21, 1911.</b>
9. AGE (In years last birthday) yrs. <b>56</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Michael Spinnato</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Marianna</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-38-3540</b>	
17. INFORMANT <b>Mr. Maurice A. Luby</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CORONARY ARTERY DISEASE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> , 19 <b>65</b> , to <b>8/1</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>8/1</b> 19 <b>67</b> , and that death occurred at <b>5:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L.P. Berger</b>		22b. DATE SIGNED <b>8/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L.P. Berger</b>		22d. ADDRESS <b>8100 Harford Rd., Balto. 34, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/5/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

1068

Baltimore

Baltimore

Baltimore

Baltimore 1137

Baltimore

2503 Pine Avenue

2503 Pine Avenue

May

May

May 21, 1911

May

May

Baltimore

Baltimore

Catharine Harbinger

Michael Harbinger

(Name)

in Baltimore, Md.

1911 - 1912

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10669

10670

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6824 Youngstown Ave. Balto., 22, Md</b>				d. STREET ADDRESS <b>6824 Youngstown Ave., Balto., 22, Md</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURA VIOIA LUTTRELL</b>				4. DATE OF DEATH Month Day Year <b>August 5, 19 67.</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 22, 1918</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Antonio Misciwowski</b>				14. MOTHER'S MAIDEN NAME <b>Laura ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-16-8520</b>		17. INFORMANT <b>Thomas R. Luttrell</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cirrhosis of liver</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6800 Morningside Rd. Balto., 21222, Md.</b> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <b>M. Davis</b>		DATE SIGNED					
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-8-67</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba.Co., Md.</b>	
23. FUNERAL DIRECTOR <b>Charles S. Zeiler</b> ADDRESS <b>6224 Eastern Ave. Balto., 21224, Md.</b>				24a. REC'D BY REGISTRAR <b>AUG 8 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

16663

Baltimore

Baltimore

Baltimore

Baltimore

6824 Youngstown Ave., Balto., Md. 6824 Youngstown Ave., Balto., Md.

August 2, 1910

June 22, 1910

U.S.A. Baltimore, Md. at home

Intorio Macdonald

217-16-9250 Thomas A. Macdonald

6800 Youngstown Rd., Balto., Md.

Kevin A. Davis

1255 Eastern Blvd., Balto., Md.

Oak Lawn Cemetery

8-8-07

6824 Youngstown Ave., Balto., Md.

AUG 1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
10670					10671										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										
a. COUNTY Baltimore					a. STATE Maryland										
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					b. COUNTY Baltimore										
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					d. STREET ADDRESS 8209 Laurel Drive										
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			Month			Day			Year			
First ANNA			Middle ROSE			Last MAGGITT			August			11 1967			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		Caucasion		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10/8/04		62 yrs.		Months		Days			
										Hours		Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) New York, New York				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Salvatore Caomo						14. MOTHER'S MAIDEN NAME Sarrese, Josephine									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. ---		17. INFORMANT Juilio Maggitti				Address					
				214-24-6477											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 12, 1967, to August 11, 1967, that (I) (we) last saw the deceased alive on August 11, 1967, and that death occurred at 12:38 AM, from the causes and on the date stated above.															
22a. SIGNATURE John E. Adams						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> P M.D.				22b. DATE SIGNED 8/11/67					
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22d. ADDRESS Greater Baltimore Medical Center									
23a. BURIAL, CREMATION, REMOVAL (Specify) Intombment				23b. DATE THEREOF 8/16/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum				23d. LOCATION (City, town or county) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR L J Ruck Inc.						ADDRESS Balto 14 Mo.		25a. REC'D BY REGISTRAR AUG 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

10700

NOTICE



Julio Martinez

AUG 1 1981

10671

## CERTIFICATE OF DEATH

10672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN lb <u>20da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u>				d. STREET ADDRESS <u>3501 ST. PAUL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Olive</u> First <u>Dashiell</u> Middle <u>Martin</u> Last				4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cav</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/1894</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Princess Ann, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Francis Dashiell</u>			
14. MOTHER'S MAIDEN NAME <u>Dashiell</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>220-05-5140</u>		17. INFORMANT <u>Patients Chart</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Nasopharyngeal Carcinoma</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>67</u> , to <u>8/14</u> , 19 <u>67</u> , that (I) (we) lost the deceased olive on <u>8/13</u> , 19 <u>67</u> , and that death occurred at <u>1:55AM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>D. C. Malrik</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8.14.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. Malrik, M.D.</u>				22d. ADDRESS <u>Greater Balto. Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/17/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Epis. Ch.</u>		23d. LOCATION (City or Town) (County) (State) <u>Princess Anne, Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co.</u>				ADDRESS <u>4905 York Road</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

5301

72-04474-72-11020

Patricia Clark

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10672						10673					
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Reisterstown RD</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Reisterstown RD</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Greenspring Ave. at Dover Rd.</i>						d. STREET ADDRESS <i>Greenspring Avenue at Dover Rd</i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First Middle Last <i>Curtis Granville McCabe, Sr.</i>			4. DATE OF DEATH Month Day Year <i>August 16, 1967 19</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>August 11, 1903</i>		9. AGE (in years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Building Inspector</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Bldg. Co., Md.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>James A. McCabe</i>						14. MOTHER'S MAIDEN NAME <i>Lola Lindsay</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>220-18-8088</i>		17. INFORMANT <i>Family Records</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V.A.D.</i> (c) <i>decompensation</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1-1-1960</i> to <i>8-16-1967</i> , that (I) (we) last saw the deceased alive on <i>8-7-1967</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>James E. Saffell</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>James E. Saffell MD</i>						22d. ADDRESS <i>Reisterstown, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>Aug. 19, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grace Falls Rd. Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Cockeysville, Md.</i>			
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>						ADDRESS		25a. REC'D BY REGISTRAR DATE <i>AUG 21 1967</i>			
								25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

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NOTES FOR THE COMMON

MINIATURE

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS 4  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

10674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2908 Emerald Rd.</b>		d. STREET ADDRESS <b>2908 Emerald Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Viola</b> First <b>McCammon</b> Last		4. DATE OF DEATH Month <b>8/</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1887</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>26</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Riley</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-54-0895</b>	
17. INFORMANT <b>Mrs. Lois Lambdin</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> <b>334x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatoid arthritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1960</b> , to <b>Aug 26, 1967</b> that I last saw the deceased alive on <b>August 25, 1967</b> , and that death occurred at <b>6:25 A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald Jandoy M.D.</b>		ADDRESS (Street, city or town, state) <b>6077 Harford Rd</b>	
DATE SIGNED <b>8-26-67</b>			
PHYSICIAN'S NAME (Type) <b>Balto, Md 21214</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/30/67</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>Balto, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 28 1967</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10073

Balto.

2208 Emerald Rd.

2208 Emerald Rd.

May 18, 1987

80

Maryland

U.S.A.

Elizabeth Moore

Joseph Riley

218-21-0022 Mrs. John Landolin same

no

8/30/87

London Pk. Com.

Balto. Md.

James J. Bush Inc. Balto. Md.

Balto. Md.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10674

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>31.4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		d. STREET ADDRESS <b>3116 Abell Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Albert McCready</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/1903</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Day id McCready</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Wyant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>192-09-6527</b>	
17. INFORMANT <b>Mrs. Rebecca E. McCready</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Sudden</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Insufficiency</b> DUE TO <b>24 yrs</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/12/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 11 1967</b>	
ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>	

1077

Belgium

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London

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St. James's Palace

St. James's Palace

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Algeria

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2/2/1903

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to

1903-1904

(1903)

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10675 Item #2 a, c & d infir. taken from birth cert. ph 10676											
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21218						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					d. STREET ADDRESS 2611 Maryland Ave. 6701 North Charles Street						
3. NAME OF DECEASED (Type or print) First Middle Last Female McDaniel					4. DATE OF DEATH Month Day Year 8 6 19 67						
5. SEX Female		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/67		9. AGE (In years last birthday) 11 days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Holland E. McDaniel					14. MOTHER'S MAIDEN NAME Frieda Pipkin						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT			Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal obstruction 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meconium Ileus DUE TO (c) Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7/26, 1967, to 8/6, 1967, that (I) (we) last saw the deceased alive on 8/6 1967, and that death occurred at 7:10 PM, from the causes and on the date stated above.											
22a. SIGNATURE [Signature]					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.			22b. DATE SIGNED 8/9/67			
22c. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M. D.					22d. ADDRESS Greater Baltimore Medical Center						
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY GBMC		23d. LOCATION (City, town or county) (State) Baltimore Md					
24. FUNERAL DIRECTOR GBMC					25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE [Signature]				

25201

*[Faint handwritten notes and stamps are visible at the bottom of the page, including "COMC" and "Baltimore".]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10676

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10677

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXX</del>		MARYLAND c. LENGTH OF STAY IN 1b <b>9 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXX</del> <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1109 Deanwood</b>		d. STREET ADDRESS <b>1109 Deanwood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN PIERCE McDONALD</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 10 1917</b>	9. AGE (In years last birthday) <b>49</b> yrs.	10. IF UNDER 1 YEAR Months <b>08</b> Days <b>19</b> Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supertendent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bendix-Friez</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Kenneth McDonald</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW2</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>August 19, 1967</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-23-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	23d. LOCATION (City or Town) _____ (County) <b>Balto Co</b> (State) <b>MD</b>		
24. FUNERAL DIRECTOR <b>C.F. EVANS &amp; SON 8802 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>AUG 22 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
10677			CERTIFICATE OF DEATH		
10678					
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>58 St. Joseph Hospital</b>			d. STREET ADDRESS <b>7620 York Road #21204</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>(DR. M. Benezetta, OSF) Helan E. McGee</b>			4. DATE OF DEATH Month Day Year <b>August 28 19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 14, 1886</b>		9. AGE (In years last birthday) <b>81</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Religious</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Patrick McGee</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-54-3311</b>		17. INFORMANT <b>St. Joseph's Hospital Records</b> Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 11, 1967</b> , to <b>August 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 28, 1967</b> , and that death occurred at <b>6:05 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Gualberto C. Gokim, Jr.</b>			22b. DATE SIGNED <b>August 28, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Gualberto Gokim, M.D.</b>			22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/31/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>			25a. REC'D BY REGISTRAR <b>DATE AUG 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10678

CERTIFICATE OF DEATH

10679

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Louisa</b> c. LENGTH OF STAY IN 1b <b>12 days</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A. A. Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>			d. STREET ADDRESS <b>7811 Winborne Dr., Apt. H</b>		
3. NAME OF DECEASED (Type or print) <b>Cyril J. McHale</b>			4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1923</b>	9. AGE (In years lost birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamship Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Lines</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>William McHale</b>			14. MOTHER'S MAIDEN NAME <b>Mary Flynn</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-12-3133</b>	17. INFORMANT <b>Mr. John McHale</b> Address <b>1312 E. Fort Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>uremia</b> DUE TO (c) <b>chronic glomerulonephritis.</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 3, 1967</b> , to <b>August 15, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 15, 1967</b> , and that death occurred at <b>5:25AM</b> , from causes and on the date stated above					
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>			22b. DATE SIGNED <b>August 15, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>			22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/18/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc</b> <b>1501 East Fort Avenue</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

100748

STATEMENT OF DATA

100748

1. The following information was obtained from the records of the Department of the Interior, Bureau of Land Management, on the subject of the land owned by the United States in the State of California, and the same is being furnished to you for your information.

2. The land owned by the United States in the State of California is divided into two classes, namely, (a) land owned by the United States in fee simple, and (b) land owned by the United States in trust for the benefit of the Indians.

3. The land owned by the United States in fee simple is divided into two classes, namely, (a) land owned by the United States in fee simple, and (b) land owned by the United States in trust for the benefit of the Indians.

4. The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, (a) land owned by the United States in trust for the benefit of the Indians, and (b) land owned by the United States in trust for the benefit of the Indians.

5. The land owned by the United States in fee simple is divided into two classes, namely, (a) land owned by the United States in fee simple, and (b) land owned by the United States in trust for the benefit of the Indians.

6. The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, (a) land owned by the United States in trust for the benefit of the Indians, and (b) land owned by the United States in trust for the benefit of the Indians.

7. The land owned by the United States in fee simple is divided into two classes, namely, (a) land owned by the United States in fee simple, and (b) land owned by the United States in trust for the benefit of the Indians.

8. The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, (a) land owned by the United States in trust for the benefit of the Indians, and (b) land owned by the United States in trust for the benefit of the Indians.

9. The land owned by the United States in fee simple is divided into two classes, namely, (a) land owned by the United States in fee simple, and (b) land owned by the United States in trust for the benefit of the Indians.

10. The land owned by the United States in trust for the benefit of the Indians is divided into two classes, namely, (a) land owned by the United States in trust for the benefit of the Indians, and (b) land owned by the United States in trust for the benefit of the Indians.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

10680

10679

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>21206</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>5812 Benton Heights Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Joseph</b> Last <b>Mc Hale</b>		4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>2</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Towson</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Martin Joseph McHale</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Maria Wustmann</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Father, above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple congenital anomalies.</b> 7593 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8/28</b> , 19 <b>67</b> , to <b>8/30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/30</b> , 19 <b>67</b> , and that death occurred at <b>8:05 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>August 31, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> <b>3331 Brehms Lane</b>		25a. RECEIVED BY REGISTRAR <b>SEP 5 1967</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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CERTIFICATE OF DEATH

10681

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21212</u> <u>031</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u>		d. STREET ADDRESS <u>211 Murdock Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Barton</u> Last <u>McLay</u>		4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years lost birthday) yrs. <u>74</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Quincy Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Barton</u>		14. MOTHER'S MAIDEN NAME <u>Atkinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-12-9448</u>	
17. INFORMANT Address <u>Mr. Jojn W. C. McLay, Same as # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> <u>CARDIO-ARTERIOSCLEROTIC VASOCLAR DISEASE</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> , 19 <u>67</u> , to <u>8/30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/29</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Luis J. Elias M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>LUIS J. ELIAS M.D.</u>		22d. ADDRESS <u>1701 MERIDENE DR.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10681

10682

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b <b>30.4</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>5515 The Alameda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lawrence E. McQUAID</b>				4. DATE OF DEATH Month Day Year <b>August 23, 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-26-1917</b>		9. AGE (In years lost birthday) <b>49 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State of Maryland</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles J. McQuaid Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ella G. <del>McQuaid</del> Tarlton</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes W.W.II</b>		16. SOCIAL SECURITY NO. <b>217-05-5338</b>		17. INFORMANT Address <b>Charles J. McQuaid Jr. 3522 Parklawn Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>acute myocardial infarction</b> DUE TO (c) <b>coronary thrombosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/18/</b> , 19 <b>67</b> , to <b>8/23/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/23/</b> 19 <b>67</b> , and that death occurred at <b>8:35</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>James J. [Signature]</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misantuk</b>				M.D. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/25/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jr</i>	

MEDICAL CERTIFICATION

12081

DATE

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10682

## CERTIFICATE OF DEATH

10683

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		d. STREET ADDRESS <b>937 RENTFREW STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL SETH MC QUAY</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 15, 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/94</b>
9. AGE (In years last birthday) yrs. <b>72</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAXI DRIVER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BOGMAN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL MC QUAY</b>		14. MOTHER'S MAIDEN NAME <b>EMILY FAULKNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>217 07 59 42</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 CORONARY THROMBOSIS</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>AUGUST 13, 19 67</b> , to <b>AUGUST 15, 19 67</b> , that <del>xx</del> (we) last saw the deceased alive on <b>AUGUST 15, 19 67</b> , and that death occurred at <b>1:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>J. D. Talbert</i>		22b. DATE SIGNED <b>8/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8 19 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>GLEN BURNIE, MD.</b>
24. FUNERAL DIRECTOR <b>MC CULLY FUNERAL HOME</b>		25. REC'D BY REGISTRAR <b>AUG 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>130 FORT AVENUE, BALTIMORE, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #23b Film #C302 8/30/67 ph			
10683		10684	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>	c. LENGTH OF STAY IN lb <b>30 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2577 E. BALTIMORE STREET</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>NMI</b> Last <b>MELLETTTE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/21/32</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>SUMTER, S. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES MELLETTTE</b>		14. MOTHER'S MAIDEN NAME <b>ABBIE MURRAY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>247 48 47 09</b>	
17. INFORMANT <b>CLINICAL RECORDS, VAH, FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO (b) <b>DIABETIC NEPHROPATHY</b> DUE TO (c) <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b> <b>YEARS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>UREMIC GASTRITIS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work ot work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/25/67</b> , 19__ to <b>8/24/67</b> , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>8/24/67</b> , 19__, and that death occurred at <b>4:35A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Neilson Neilson</i>		22b. DATE SIGNED <b>8/24/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MC CRIMMON FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		25c. ADDRESS <b>2302 W. NORTH AVENUE, BALTIMORE, MD.</b>	

10783

BALTIMORE

BALTIMORE

PORT HOWARD

30 DATE

BALTIMORE

VETERANS ADMINISTRATION HOSPITAL

2511 E. BALTIMORE STREET

JOSEPH

WILL

WILLIAMS

AUGUST 24

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MALE NEGRO

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LADDER

SUMMER, S. CAROLINA

U.S.A.

JAMES WILLIAMS

ABILE MURRAY

YES

214 18 11 09 CLINICAL RECORDS, VAN, IT. HOWARD, MD.

UNIT 1A

STANDARD INTERNATIONAL

CLINICAL RECORDS

CLINICAL RECORDS

HOWARD

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8/24/32

4:32

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VAN HONG HOWARD, VAN

WILLIAM WILLIAMS, W. D.

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WILLIAM WILLIAMS, W. D.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)  
6M 1/66

10684

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10685

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Westminster Road</i>			d. STREET ADDRESS <i>Kemp Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E.</i> Last <i>Merryman</i>			4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>1967</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 31, 1933</i>	9. AGE (In years last birthday) <i>33</i> yrs.	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Jake B. Wade</i>			14. MOTHER'S MAIDEN NAME <i>Ruth A. Salyer</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-32-2796</i>		17. INFORMANT <i>Mr. Gilbert A. Merryman</i> Address <i>Reisterstown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lacerations of face &amp; throat; Fractured rt. elbow; Multiple fractures of facial bones</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Apparent driver of car involved in 2 car collision</i>			
20c. TIME OF INJURY Month, Day, Year <i>2:40 p.m. Aug 20 1967</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Westminster Rd.</i>	
				20f. (City or town) (County) (State) <i>Reisterstown Balto Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>D. D. Caples</i>		M.D.		22. DATE SIGNED <i>8-21-67</i>	
EXAMINER'S NAME (Type) <i>D. D. Caples, M. D.</i>		6 Hanover Rd. <i>Reisterstown, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 23, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i>	
				23d. LOCATION (City or Town) (County) (State) <i>Sykesville, Md.</i>	
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons</i>		ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 23 1967</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10685

CERTIFICATE OF DEATH

10686

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT 3 BOX 482 PASADENA, MD. AA CO.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>RT 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY PATRICK MICHAELS</b>			4. DATE OF DEATH Month Day Year <b>AUGUST 3 19 67</b>			IF UNDER 1 YEAR Months Days Hours Min.	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/99</b>		9. AGE (In years lost birthday) <b>68 yrs.</b>	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMILE MICHAELS</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET JONES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES ARMY</b>		16. SOCIAL SECURITY NO. <b>215 03 59 24</b>		17. INFORMANT Address <b>CLINICAL RECORDS VAH FORT HOWARD, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA FACE AND NECK WITH METASTASIS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1918</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 25</b> , 19 <b>67</b> , to <b>AUGUST 3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 3</b> , 19 <b>67</b> and that death occurred on <b>9:40 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>George C. McElpatrick</i>				22b. DATE SIGNED <b>AUGUST 3, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>(SINGLETON) BALTIMORE NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>FREDERICK AVEN.</b>	
24. FUNERAL DIRECTOR <b>SINGLETON FUNERAL HOME</b> <i>Robert V. ...</i>				25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>		25b. REGISTRAR'S SIGNATURE <i>John ...</i>	

10083

MAINTENANCE

MAINTENANCE

NO. 3 BOX 400 PARADISE, N.Y. 100

JOHN HOWARD

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VERMONT STATEMENT OF WORK

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10686

CERTIFICATE OF DEATH

10687

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>4 YEARS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MASONIC HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>LOU</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/26/81</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U-S</b>	
13. FATHER'S NAME <b>JOHN HENRY MILLER</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN WHITEMORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-07-7291</b>	
17. INFORMANT <b>MASONIC HOME RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Arteriosclerotic heart disease</b> DUE TO (b) <b>3 Cerebral arteriosclerosis</b> DUE TO (c) <b>3, Excessive Smoking &amp; fracture Rt. Hip</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>415 BRONCHOPNEUMONIA, terminal</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>65</b> to <b>July 31</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>July 31</b> , 19 <b>67</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>JAMES HAD HAMED</b>		22b. DATE SIGNED <b>8/1/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES HAD HAMED</b>		22d. ADDRESS <b>MASONIC HOME</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Aug. 4, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT Zion's Lutheran</b>	23d. LOCATION (City or Town) (County) (State) <b>FREDERICK Co. MD</b>
24. FUNERAL DIRECTOR <b>Wm Cook - Brooks Towson</b>		25a. REC'D BY REGISTRAR <b>Towson, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>		DATE <b>AUG 4 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10688

EXHIBIT 10688

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10/10/01 BY 60322 UCBAW/SJS/KJS

FOR STATE  
HEALTH DEPT.

10687

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10688

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>83-3</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt. Wilson</i>		c. LENGTH OF STAY IN 1b <i>3 hrs 4 min</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salem</i>		d. STREET ADDRESS <i>83-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Mt Wilson State Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>HENRY</i>		4. DATE OF DEATH <i>Aug 5 19 67</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/21/06</i>
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Miller</i>		14. MOTHER'S MAIDEN NAME <i>Amy Sheffey</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mt. Wilson Hosp. Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Collapse</i> DUE TO (b) <i>Pulmonary T.B - far adv. - active</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>3 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>None</i> p.m. <i>None</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <i>8/5/67</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/8/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>West End Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Wytheville, Va.</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Inc Baltimore, Md. 21202</i>		25a. REC'D BY REGISTRAR <i>AUG 9 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

10689

10688

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Maryland</b>			c. LENGTH OF STAY IN lb <b>1mth10dys</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 21230</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				d. STREET ADDRESS <b>501 E. Fort Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Moran Miller</b>				4. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1906</b>		9. AGE (In years lost birthday) yrs. <b>61</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Miller</b>				14. MOTHER'S MAIDEN NAME <b>Marguerita Schuman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>216-09-5110</b>		17. INFORMANT Address <b>Records: Spring Grove State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>163X</b> IMMEDIATE CAUSE (a) <b>Brain Tumors, metastatic from (b)</b> DUE TO (b) <b>Carcinoma of the Lung (histopathology unk.)</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>July 13, 1967</b> , to <b>Aug. 23, 1967</b> , that <del>(x)</del> (we) last saw the deceased alive on <b>Aug. 23, 1967</b> , and that death occurred at <b>5:15</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Anthony J. Young</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-23-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>				22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8 26 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR <b>Mc Cully</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 24 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10228

CERTIFICATE OF DEATH

California, Berkeley

in 1900

California, Berkeley

501 E. 10th Avenue

Berkeley Grove State Hospital

Miller

Kotow

John

1900

White

White

Janet

Charles Miller

210-09-2100 - Jackson: Police Grove State Hospital

Unknown

Real: Unknown, suspected: from (b)

Investment of the fund (State Police unit) 1900

July 12 1900

19

1900

1900-1901

Berkeley Grove State Hospital

Berkeley, California 94703

1900-1901

1900-1901

1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)  
6M 1/67

FOR STATE  
HEALTH DEPT.

1

10689

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10690

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>2346 York Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH ADY MILLER</b>		4. DATE OF DEATH <b>August 23, 1967</b>		Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan, 28, 1916</b>		9. AGE (In years lost birthday) <b>51 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Delicatessen (Owner)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pheonix, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph C. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Ady</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-6810</b>		17. INFORMANT <b>Mrs. Virginia H. Miller 2346 York Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
21. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED <b>8/23/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/26/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessop Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

10088

AUG 10 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10690

CERTIFICATE OF DEATH

10691

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>4 yrs. 5 mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		13-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stella Maris Hospice</b>		d. STREET ADDRESS <b>2017 Hillcrest Rd. 21207</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Louise Ann Miller</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>25</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 14, 1895</b>
9. AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HWI.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John C. Harting</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Fleishhman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-16--6720B</b>	
17. INFORMANT <b>Mary L. Miller - 3702 N. Rogers Ave</b> <b>Records Stella Maris Hospice</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Thrombosis</b> DUE TO (b) <b>Ascend</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>14 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/5/65</b> , 19 <b>65</b> , to <b>8/25/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/22/67</b> , 19 <b>67</b> , and that death occurred at <b>4A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert J. Mahon</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, M.D.</b>		22d. ADDRESS <b>204 E. Joppa</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-28-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, Md</b>	
24. FUNERAL DIRECTOR <b>Ells Worth Armacost</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 28 1967</b>	
ADDRESS <b>4600 Liberty Heights Ave</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

STATE OF TEXAS

10000

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at the City of Austin, this 1st day of January, 1900.

Attest:

Notary Public in and for the State of Texas

My Comm. Expires Jan 1, 1901



10691

CERTIFICATE OF DEATH

10692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>		d. STREET ADDRESS <u>3 Ashmore Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Marie B. Mitzell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. Peter Dorn</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wheeler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-079799</u>	
17. INFORMANT <u>Ny/ home chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>40 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebrovascular Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>67</u> , to <u>8/16</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8/16</u> , 19 <u>67</u> , and that death occurred at <u>9:00 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Wade E. J. H. Jones</u>		22b. DATE SIGNED <u>8/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wade E. J. H. Jones</u>		22d. ADDRESS <u>414 W. Lomb. Elliott City</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug. 19, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. J. Schelhardt</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 21 1967</u>	

100231

STATEMENT OF DEBIT

UNITED STATES DEPARTMENT OF THE ARMY, WASHINGTON, D.C. 20315

1. NAME OF THE DEBTOR		2. ADDRESS OF THE DEBTOR	
3. DATE OF DEBIT		4. AMOUNT OF DEBIT	
5. DESCRIPTION OF DEBIT		6. DATE OF PAYMENT	
7. NAME OF THE CREDITOR		8. ADDRESS OF THE CREDITOR	
9. DATE OF PAYMENT		10. AMOUNT OF PAYMENT	
11. DESCRIPTION OF PAYMENT		12. DATE OF RECEIPT	
13. NAME OF THE DEBTOR		14. ADDRESS OF THE DEBTOR	
15. DATE OF DEBIT		16. AMOUNT OF DEBIT	
17. DESCRIPTION OF DEBIT		18. DATE OF PAYMENT	
19. NAME OF THE CREDITOR		20. ADDRESS OF THE CREDITOR	
21. DATE OF PAYMENT		22. AMOUNT OF PAYMENT	
23. DESCRIPTION OF PAYMENT		24. DATE OF RECEIPT	
25. NAME OF THE DEBTOR		26. ADDRESS OF THE DEBTOR	
27. DATE OF DEBIT		28. AMOUNT OF DEBIT	
29. DESCRIPTION OF DEBIT		30. DATE OF PAYMENT	
31. NAME OF THE CREDITOR		32. ADDRESS OF THE CREDITOR	
33. DATE OF PAYMENT		34. AMOUNT OF PAYMENT	
35. DESCRIPTION OF PAYMENT		36. DATE OF RECEIPT	
37. NAME OF THE DEBTOR		38. ADDRESS OF THE DEBTOR	
39. DATE OF DEBIT		40. AMOUNT OF DEBIT	
41. DESCRIPTION OF DEBIT		42. DATE OF PAYMENT	
43. NAME OF THE CREDITOR		44. ADDRESS OF THE CREDITOR	
45. DATE OF PAYMENT		46. AMOUNT OF PAYMENT	
47. DESCRIPTION OF PAYMENT		48. DATE OF RECEIPT	
49. NAME OF THE DEBTOR		50. ADDRESS OF THE DEBTOR	
51. DATE OF DEBIT		52. AMOUNT OF DEBIT	
53. DESCRIPTION OF DEBIT		54. DATE OF PAYMENT	
55. NAME OF THE CREDITOR		56. ADDRESS OF THE CREDITOR	
57. DATE OF PAYMENT		58. AMOUNT OF PAYMENT	
59. DESCRIPTION OF PAYMENT		60. DATE OF RECEIPT	
61. NAME OF THE DEBTOR		62. ADDRESS OF THE DEBTOR	
63. DATE OF DEBIT		64. AMOUNT OF DEBIT	
65. DESCRIPTION OF DEBIT		66. DATE OF PAYMENT	
67. NAME OF THE CREDITOR		68. ADDRESS OF THE CREDITOR	
69. DATE OF PAYMENT		70. AMOUNT OF PAYMENT	
71. DESCRIPTION OF PAYMENT		72. DATE OF RECEIPT	
73. NAME OF THE DEBTOR		74. ADDRESS OF THE DEBTOR	
75. DATE OF DEBIT		76. AMOUNT OF DEBIT	
77. DESCRIPTION OF DEBIT		78. DATE OF PAYMENT	
79. NAME OF THE CREDITOR		80. ADDRESS OF THE CREDITOR	
81. DATE OF PAYMENT		82. AMOUNT OF PAYMENT	
83. DESCRIPTION OF PAYMENT		84. DATE OF RECEIPT	
85. NAME OF THE DEBTOR		86. ADDRESS OF THE DEBTOR	
87. DATE OF DEBIT		88. AMOUNT OF DEBIT	
89. DESCRIPTION OF DEBIT		90. DATE OF PAYMENT	
91. NAME OF THE CREDITOR		92. ADDRESS OF THE CREDITOR	
93. DATE OF PAYMENT		94. AMOUNT OF PAYMENT	
95. DESCRIPTION OF PAYMENT		96. DATE OF RECEIPT	
97. NAME OF THE DEBTOR		98. ADDRESS OF THE DEBTOR	
99. DATE OF DEBIT		100. AMOUNT OF DEBIT	
101. DESCRIPTION OF DEBIT		102. DATE OF PAYMENT	
103. NAME OF THE CREDITOR		104. ADDRESS OF THE CREDITOR	
105. DATE OF PAYMENT		106. AMOUNT OF PAYMENT	
107. DESCRIPTION OF PAYMENT		108. DATE OF RECEIPT	
109. NAME OF THE DEBTOR		110. ADDRESS OF THE DEBTOR	
111. DATE OF DEBIT		112. AMOUNT OF DEBIT	
113. DESCRIPTION OF DEBIT		114. DATE OF PAYMENT	
115. NAME OF THE CREDITOR		116. ADDRESS OF THE CREDITOR	
117. DATE OF PAYMENT		118. AMOUNT OF PAYMENT	
119. DESCRIPTION OF PAYMENT		120. DATE OF RECEIPT	
121. NAME OF THE DEBTOR		122. ADDRESS OF THE DEBTOR	
123. DATE OF DEBIT		124. AMOUNT OF DEBIT	
125. DESCRIPTION OF DEBIT		126. DATE OF PAYMENT	
127. NAME OF THE CREDITOR		128. ADDRESS OF THE CREDITOR	
129. DATE OF PAYMENT		130. AMOUNT OF PAYMENT	
131. DESCRIPTION OF PAYMENT		132. DATE OF RECEIPT	
133. NAME OF THE DEBTOR		134. ADDRESS OF THE DEBTOR	
135. DATE OF DEBIT		136. AMOUNT OF DEBIT	
137. DESCRIPTION OF DEBIT		138. DATE OF PAYMENT	
139. NAME OF THE CREDITOR		140. ADDRESS OF THE CREDITOR	
141. DATE OF PAYMENT		142. AMOUNT OF PAYMENT	
143. DESCRIPTION OF PAYMENT		144. DATE OF RECEIPT	
145. NAME OF THE DEBTOR		146. ADDRESS OF THE DEBTOR	
147. DATE OF DEBIT		148. AMOUNT OF DEBIT	
149. DESCRIPTION OF DEBIT		150. DATE OF PAYMENT	
151. NAME OF THE CREDITOR		152. ADDRESS OF THE CREDITOR	
153. DATE OF PAYMENT		154. AMOUNT OF PAYMENT	
155. DESCRIPTION OF PAYMENT		156. DATE OF RECEIPT	
157. NAME OF THE DEBTOR		158. ADDRESS OF THE DEBTOR	
159. DATE OF DEBIT		160. AMOUNT OF DEBIT	
161. DESCRIPTION OF DEBIT		162. DATE OF PAYMENT	
163. NAME OF THE CREDITOR		164. ADDRESS OF THE CREDITOR	
165. DATE OF PAYMENT		166. AMOUNT OF PAYMENT	
167. DESCRIPTION OF PAYMENT		168. DATE OF RECEIPT	
169. NAME OF THE DEBTOR		170. ADDRESS OF THE DEBTOR	
171. DATE OF DEBIT		172. AMOUNT OF DEBIT	
173. DESCRIPTION OF DEBIT		174. DATE OF PAYMENT	
175. NAME OF THE CREDITOR		176. ADDRESS OF THE CREDITOR	
177. DATE OF PAYMENT		178. AMOUNT OF PAYMENT	
179. DESCRIPTION OF PAYMENT		180. DATE OF RECEIPT	
181. NAME OF THE DEBTOR		182. ADDRESS OF THE DEBTOR	
183. DATE OF DEBIT		184. AMOUNT OF DEBIT	
185. DESCRIPTION OF DEBIT		186. DATE OF PAYMENT	
187. NAME OF THE CREDITOR		188. ADDRESS OF THE CREDITOR	
189. DATE OF PAYMENT		190. AMOUNT OF PAYMENT	
191. DESCRIPTION OF PAYMENT		192. DATE OF RECEIPT	
193. NAME OF THE DEBTOR		194. ADDRESS OF THE DEBTOR	
195. DATE OF DEBIT		196. AMOUNT OF DEBIT	
197. DESCRIPTION OF DEBIT		198. DATE OF PAYMENT	
199. NAME OF THE CREDITOR		200. ADDRESS OF THE CREDITOR	
201. DATE OF PAYMENT		202. AMOUNT OF PAYMENT	
203. DESCRIPTION OF PAYMENT		204. DATE OF RECEIPT	
205. NAME OF THE DEBTOR		206. ADDRESS OF THE DEBTOR	
207. DATE OF DEBIT		208. AMOUNT OF DEBIT	
209. DESCRIPTION OF DEBIT		210. DATE OF PAYMENT	
211. NAME OF THE CREDITOR		212. ADDRESS OF THE CREDITOR	
213. DATE OF PAYMENT		214. AMOUNT OF PAYMENT	
215. DESCRIPTION OF PAYMENT		216. DATE OF RECEIPT	
217. NAME OF THE DEBTOR		218. ADDRESS OF THE DEBTOR	
219. DATE OF DEBIT		220. AMOUNT OF DEBIT	
221. DESCRIPTION OF DEBIT		222. DATE OF PAYMENT	
223. NAME OF THE CREDITOR		224. ADDRESS OF THE CREDITOR	
225. DATE OF PAYMENT		226. AMOUNT OF PAYMENT	
227. DESCRIPTION OF PAYMENT		228. DATE OF RECEIPT	
229. NAME OF THE DEBTOR		230. ADDRESS OF THE DEBTOR	
231. DATE OF DEBIT		232. AMOUNT OF DEBIT	
233. DESCRIPTION OF DEBIT		234. DATE OF PAYMENT	
235. NAME OF THE CREDITOR		236. ADDRESS OF THE CREDITOR	
237. DATE OF PAYMENT		238. AMOUNT OF PAYMENT	
239. DESCRIPTION OF PAYMENT		240. DATE OF RECEIPT	
241. NAME OF THE DEBTOR		242. ADDRESS OF THE DEBTOR	
243. DATE OF DEBIT		244. AMOUNT OF DEBIT	
245. DESCRIPTION OF DEBIT		246. DATE OF PAYMENT	
247. NAME OF THE CREDITOR		248. ADDRESS OF THE CREDITOR	
249. DATE OF PAYMENT		250. AMOUNT OF PAYMENT	
251. DESCRIPTION OF PAYMENT		252. DATE OF RECEIPT	
253. NAME OF THE DEBTOR		254. ADDRESS OF THE DEBTOR	
255. DATE OF DEBIT		256. AMOUNT OF DEBIT	
257. DESCRIPTION OF DEBIT		258. DATE OF PAYMENT	
259. NAME OF THE CREDITOR		260. ADDRESS OF THE CREDITOR	
261. DATE OF PAYMENT		262. AMOUNT OF PAYMENT	
263. DESCRIPTION OF PAYMENT		264. DATE OF RECEIPT	
265. NAME OF THE DEBTOR		266. ADDRESS OF THE DEBTOR	
267. DATE OF DEBIT		268. AMOUNT OF DEBIT	
269. DESCRIPTION OF DEBIT		270. DATE OF PAYMENT	
271. NAME OF THE CREDITOR		272. ADDRESS OF THE CREDITOR	
273. DATE OF PAYMENT		274. AMOUNT OF PAYMENT	
275. DESCRIPTION OF PAYMENT		276. DATE OF RECEIPT	
277. NAME OF THE DEBTOR		278. ADDRESS OF THE DEBTOR	
279. DATE OF DEBIT		280. AMOUNT OF DEBIT	
281. DESCRIPTION OF DEBIT		282. DATE OF PAYMENT	
283. NAME OF THE CREDITOR		284. ADDRESS OF THE CREDITOR	
285. DATE OF PAYMENT		286. AMOUNT OF PAYMENT	
287. DESCRIPTION OF PAYMENT		288. DATE OF RECEIPT	
289. NAME OF THE DEBTOR		290. ADDRESS OF THE DEBTOR	
291. DATE OF DEBIT		292. AMOUNT OF DEBIT	
293. DESCRIPTION OF DEBIT		294. DATE OF PAYMENT	
295. NAME OF THE CREDITOR		296. ADDRESS OF THE CREDITOR	
297. DATE OF PAYMENT		298. AMOUNT OF PAYMENT	
299. DESCRIPTION OF PAYMENT		300. DATE OF RECEIPT	
301. NAME OF THE DEBTOR		302. ADDRESS OF THE DEBTOR	
303. DATE OF DEBIT		304. AMOUNT OF DEBIT	
305. DESCRIPTION OF DEBIT		306. DATE OF PAYMENT	
307. NAME OF THE CREDITOR		308. ADDRESS OF THE CREDITOR	
309. DATE OF PAYMENT		310. AMOUNT OF PAYMENT	
311. DESCRIPTION OF PAYMENT		312. DATE OF RECEIPT	
313. NAME OF THE DEBTOR		314. ADDRESS OF THE DEBTOR	
315. DATE OF DEBIT		316. AMOUNT OF DEBIT	
317. DESCRIPTION OF DEBIT		318. DATE OF PAYMENT	
319. NAME OF THE CREDITOR		320. ADDRESS OF THE CREDITOR	
321. DATE OF PAYMENT		322. AMOUNT OF PAYMENT	
323. DESCRIPTION OF PAYMENT		324. DATE OF RECEIPT	
325. NAME OF THE DEBTOR		326. ADDRESS OF THE DEBTOR	
327. DATE OF DEBIT		328. AMOUNT OF DEBIT	
329. DESCRIPTION OF DEBIT		330. DATE OF PAYMENT	
331. NAME OF THE CREDITOR		332. ADDRESS OF THE CREDITOR	
333. DATE OF PAYMENT		334. AMOUNT OF PAYMENT	
335. DESCRIPTION OF PAYMENT		336. DATE OF RECEIPT	
337. NAME OF THE DEBTOR		338. ADDRESS OF THE DEBTOR	
339. DATE OF DEBIT		340. AMOUNT OF DEBIT	
341. DESCRIPTION OF DEBIT		342. DATE OF PAYMENT	
343. NAME OF THE CREDITOR		344. ADDRESS OF THE CREDITOR	
345. DATE OF PAYMENT		346. AMOUNT OF PAYMENT	
347. DESCRIPTION OF PAYMENT		348. DATE OF RECEIPT	
349. NAME OF THE DEBTOR		350. ADDRESS OF THE DEBTOR	
351. DATE OF DEBIT		352. AMOUNT OF DEBIT	
353. DESCRIPTION OF DEBIT		354. DATE OF PAYMENT	
355. NAME OF THE CREDITOR		356. ADDRESS OF THE CREDITOR	
357. DATE OF PAYMENT		358. AMOUNT OF PAYMENT	
359. DESCRIPTION OF PAYMENT		360. DATE OF RECEIPT	
361. NAME OF THE DEBTOR		362. ADDRESS OF THE DEBTOR	
363. DATE OF DEBIT		364. AMOUNT OF DEBIT	
365. DESCRIPTION OF DEBIT		366. DATE OF PAYMENT	
367. NAME OF THE CREDITOR		368. ADDRESS OF THE CREDITOR	
369. DATE OF PAYMENT		370. AMOUNT OF PAYMENT	
371. DESCRIPTION OF PAYMENT		372. DATE OF RECEIPT	
373. NAME OF THE DEBTOR		374. ADDRESS OF THE DEBTOR	
375. DATE OF DEBIT		376. AMOUNT OF DEBIT	
377. DESCRIPTION OF DEBIT		378. DATE OF PAYMENT	
379. NAME OF THE CREDITOR		380. ADDRESS OF THE CREDITOR	
381. DATE OF PAYMENT		382. AMOUNT OF PAYMENT	
383. DESCRIPTION OF PAYMENT		384. DATE OF RECEIPT	
385. NAME OF THE DEBTOR		386. ADDRESS OF THE DEBTOR	
387. DATE OF DEBIT		388. AMOUNT OF DEBIT	
389. DESCRIPTION OF DEBIT		390. DATE OF PAYMENT	
391. NAME OF THE CREDITOR		392. ADDRESS OF THE CREDITOR	
393. DATE OF PAYMENT		394. AMOUNT OF PAYMENT	
395. DESCRIPTION OF PAYMENT		396. DATE OF RECEIPT	
397. NAME OF THE DEBTOR		398. ADDRESS OF THE DEBTOR	
399. DATE OF DEBIT		400. AMOUNT OF DEBIT	
401. DESCRIPTION OF DEBIT		402. DATE OF PAYMENT	
403. NAME OF THE CREDITOR		404. ADDRESS OF THE CREDITOR	
405. DATE OF PAYMENT		406. AMOUNT OF PAYMENT	
407. DESCRIPTION OF PAYMENT		408. DATE OF RECEIPT	
409. NAME OF THE DEBTOR		410. ADDRESS OF THE DEBTOR	
411. DATE OF DEBIT		412. AMOUNT OF DEBIT	
413. DESCRIPTION OF DEBIT		414. DATE OF PAYMENT	
415. NAME OF THE CREDITOR		416. ADDRESS OF THE CREDITOR	
417. DATE OF PAYMENT		418. AMOUNT OF PAYMENT	
419. DESCRIPTION OF PAYMENT		420. DATE OF RECEIPT	
421. NAME OF THE DEBTOR		422. ADDRESS OF THE DEBTOR	
423. DATE OF DEBIT		424. AMOUNT OF DEBIT	
425. DESCRIPTION OF DEBIT		426. DATE OF PAYMENT	
427. NAME OF THE CREDITOR		428. ADDRESS OF THE CREDITOR	
429. DATE OF PAYMENT		430. AMOUNT OF PAYMENT	
431. DESCRIPTION OF PAYMENT		432. DATE OF RECEIPT	
433. NAME OF THE DEBTOR		434. ADDRESS OF THE DEBTOR	
435. DATE OF DEBIT		436. AMOUNT OF DEBIT	
437. DESCRIPTION OF DEBIT		438. DATE OF PAYMENT	
439. NAME OF THE CREDITOR		440. ADDRESS OF THE CREDITOR	
441. DATE OF PAYMENT		442. AMOUNT OF PAYMENT	
443. DESCRIPTION OF PAYMENT		444. DATE OF RECEIPT	
445. NAME OF THE DEBTOR		446. ADDRESS OF THE DEBTOR	
447. DATE OF DEBIT		448. AMOUNT OF DEBIT	
449. DESCRIPTION OF DEBIT		450. DATE OF PAYMENT	
451. NAME OF THE CREDITOR		452. ADDRESS OF THE CREDITOR	
453. DATE OF PAYMENT		454. AMOUNT OF PAYMENT	
455. DESCRIPTION OF PAYMENT		456. DATE OF RECEIPT	
457. NAME OF THE DEBTOR		458. ADDRESS OF THE DEBTOR	
459. DATE OF DEBIT		460. AMOUNT OF DEBIT	
461. DESCRIPTION OF DEBIT		462. DATE OF PAYMENT	
463. NAME OF THE CREDITOR		464. ADDRESS OF THE CREDITOR	
465. DATE OF PAYMENT		466. AMOUNT OF PAYMENT	
467. DESCRIPTION OF PAYMENT		468. DATE OF RECEIPT	
469. NAME OF THE DEBTOR		470. ADDRESS OF THE DEBTOR	
471. DATE OF DEBIT		472. AMOUNT OF DEBIT	
473. DESCRIPTION OF DEBIT		474. DATE OF PAYMENT	
475. NAME OF THE CREDITOR		476. ADDRESS OF THE CREDITOR	
477. DATE OF PAYMENT		478. AMOUNT OF PAYMENT	
479. DESCRIPTION OF PAYMENT		480. DATE OF RECEIPT	
481. NAME OF THE DEBTOR		482. ADDRESS OF THE DEBTOR	
483. DATE OF DEBIT		484. AMOUNT OF DEBIT	
485. DESCRIPTION OF DEBIT		486. DATE OF PAYMENT	
487. NAME OF THE CREDITOR		488. ADDRESS OF THE CREDITOR	
489. DATE OF PAYMENT		490. AMOUNT OF PAYMENT	
491. DESCRIPTION OF PAYMENT		492. DATE OF RECEIPT	
493. NAME OF THE DEBTOR		494. ADDRESS OF THE DEBTOR	
495. DATE OF DEBIT		496. AMOUNT OF DEBIT	
497. DESCRIPTION OF DEBIT		498. DATE OF PAYMENT	
499. NAME OF THE CREDITOR		500. ADDRESS OF THE CREDITOR	
501. DATE OF PAYMENT		502. AMOUNT OF PAYMENT	
503. DESCRIPTION OF PAYMENT		504. DATE OF RECEIPT	
505. NAME OF THE DEBTOR		506. ADDRESS OF THE DEBTOR	
507. DATE OF DEBIT		508. AMOUNT OF DEBIT	
509. DESCRIPTION OF DEBIT		510. DATE OF PAYMENT	
511. NAME OF THE CREDITOR		512. ADDRESS OF THE CREDITOR	
513. DATE OF PAYMENT		514. AMOUNT OF PAYMENT	
515. DESCRIPTION OF PAYMENT		516. DATE OF RECEIPT	
517. NAME OF THE DEBTOR		518. ADDRESS OF THE DEBTOR	
519. DATE OF DEBIT		520. AMOUNT OF DEBIT	
521. DESCRIPTION OF DEBIT		522. DATE OF PAYMENT	
523. NAME OF THE CREDITOR		524. ADDRESS OF THE CREDITOR	
525. DATE OF PAYMENT		526. AMOUNT OF PAYMENT	
527. DESCRIPTION OF PAYMENT		528. DATE OF RECEIPT	
529. NAME OF THE DEBTOR		530. ADDRESS OF THE DEBTOR	
531. DATE OF DEBIT		532. AMOUNT OF DEBIT	
533. DESCRIPTION OF DEBIT		534. DATE OF PAYMENT	
535. NAME OF THE CREDITOR		536. ADDRESS OF THE CREDITOR	
537. DATE OF PAYMENT		538. AMOUNT OF PAYMENT	
539. DESCRIPTION OF PAYMENT		540. DATE OF RECEIPT	
541. NAME OF THE DEBTOR		542. ADDRESS OF THE DEBTOR	
543. DATE OF DEBIT		544. AMOUNT OF DEBIT	
545. DESCRIPTION OF DEBIT		546. DATE OF PAYMENT	
547. NAME OF THE CREDITOR		548. ADDRESS OF THE CREDITOR	
549. DATE OF PAYMENT		550. AMOUNT OF PAYMENT	
551. DESCRIPTION OF PAYMENT		552. DATE OF RECEIPT	
553. NAME OF THE DEBTOR		554. ADDRESS OF THE DEBTOR	
555. DATE OF DEBIT		556. AMOUNT OF DEBIT	
557. DESCRIPTION OF DEBIT		558. DATE OF PAYMENT	
559. NAME OF THE CREDITOR		560. ADDRESS OF THE CREDITOR	
561. DATE OF PAYMENT		562. AMOUNT OF PAYMENT	
563. DESCRIPTION OF PAYMENT		564. DATE OF RECEIPT	
565. NAME OF THE DEBTOR		566. ADDRESS OF THE DEBTOR	
567. DATE OF DEBIT		568. AMOUNT OF DEBIT	
569. DESCRIPTION OF DEBIT		570. DATE OF PAYMENT	
571. NAME OF THE CREDITOR		572. ADDRESS OF THE CREDITOR	
573. DATE OF PAYMENT		574. AMOUNT OF PAYMENT	
575. DESCRIPTION OF PAYMENT		576. DATE OF RECEIPT	
577. NAME OF THE DEBTOR		578. ADDRESS OF THE DEBTOR	
579. DATE OF DEBIT		580. AMOUNT OF DEBIT	
581. DESCRIPTION OF DEBIT		582. DATE OF PAYMENT	
583. NAME OF THE CREDITOR		584. ADDRESS OF THE CREDITOR	
585. DATE OF PAYMENT		586. AMOUNT OF PAYMENT	
587. DESCRIPTION OF PAYMENT		588. DATE OF RECEIPT	
589. NAME OF THE DEBTOR		590. ADDRESS OF THE DEBTOR	
591. DATE OF DEBIT		592. AMOUNT OF DEBIT	
593. DESCRIPTION OF DEBIT		594. DATE OF PAYMENT	
595. NAME OF THE CREDITOR		596. ADDRESS OF THE CREDITOR	
597. DATE OF PAYMENT		598. AMOUNT OF PAYMENT	
599. DESCRIPTION OF PAYMENT		600. DATE OF RECEIPT	
601. NAME OF THE DEBTOR		602. ADDRESS OF THE DEBTOR	
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605. DESCRIPTION OF DEBIT		606. DATE OF PAYMENT	
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613. NAME OF THE DEBTOR		614. ADDRESS OF THE DEBTOR	
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617. DESCRIPTION OF DEBIT		618. DATE OF PAYMENT	
619. NAME OF THE CREDITOR		620. ADDRESS OF THE CREDITOR	
621. DATE OF PAYMENT		622. AMOUNT OF PAYMENT	
623. DESCRIPTION OF PAYMENT		624. DATE OF RECEIPT	
625. NAME OF THE DEBTOR		626. ADDRESS OF THE DEBTOR	
627. DATE OF DEBIT		628. AMOUNT OF DEBIT	
629. DESCRIPTION OF DEBIT		630. DATE OF PAYMENT	
631. NAME OF THE CREDITOR		632. ADDRESS OF THE CREDITOR	
633. DATE OF PAYMENT		634. AMOUNT OF PAYMENT	
635. DESCRIPTION OF PAYMENT		636. DATE OF RECEIPT	
637. NAME OF THE DEBTOR		638. ADDRESS OF THE DEBTOR	
639. DATE OF DEBIT		640. AMOUNT OF DEBIT	
641. DESCRIPTION OF DEBIT		642. DATE OF PAYMENT	
643. NAME OF THE CREDITOR		644. ADDRESS OF THE CREDITOR	
645. DATE OF PAYMENT		646. AMOUNT OF PAYMENT	
647. DESCRIPTION OF PAYMENT		648. DATE OF RECEIPT	
649. NAME OF THE DEBTOR		650. ADDRESS OF THE DEBTOR	
651. DATE OF DEBIT		652. AMOUNT OF DEBIT	
653. DESCRIPTION OF DEBIT		654. DATE OF PAYMENT	
655. NAME OF THE CREDITOR		656. ADDRESS OF THE CREDITOR	
657. DATE OF PAYMENT		658. AMOUNT OF PAYMENT	
659. DESCRIPTION OF PAYMENT		660. DATE OF RECEIPT	
661. NAME OF THE DEBTOR		662. ADDRESS OF THE DEBTOR	
663. DATE OF DEBIT			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10692

CERTIFICATE OF DEATH

10693

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY in 1b <b>37 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPARROWS POINT</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WALTER J. MOORE</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 11 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1901</b>
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL COMPANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ROCKSBORO, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILL MOORE</b>		14. MOTHER'S MAIDEN NAME <b>TINY PAILEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213 09 15 52</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL,</b>		Address <b>FT HOWARD, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 4201 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTESTINAL OBSTRUCTION</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>7/5/67</b> , 19__, to <b>8/11/67</b> , 19__, that (we) last saw the deceased alive on <b>8/11/67</b> , 19__, and that death occurred <b>12:00 Noon</b> on <b>8/11/67</b> , 19__, and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED <b>8/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>MILTON GINSBERG, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-15-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT FUNERAL HOME</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

10693

BY DATE

PORT HONOR

623 "1" BY DATE

VALENTINE AMBROSIO HOSPITAL

7.

OWNER

28

2-18-1901

STILL COAST

TRUCK DRIVER

TIME TABLE

WILL DOOR

U.S. DEPT. OF JUSTICE, WASHINGTON, D.C.

Y.S. DEPT. OF JUSTICE

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

2/11/01

TABLE

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

8-12-01

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10693

CERTIFICATE OF DEATH

10684

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Agd. Roomers Mrs's Homes</u>		d. STREET ADDRESS <u>615 Chestnut Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Grey</u> Middle <u>Moore</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-88</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>2</u> Min <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Vicksburg, Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Meyers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>710-09-600</u>	
17. INFORMANT <u>Helen M. Strickfus</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma Parathyroid Gland with metastases</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Radical Neck Surgery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 18</u> , 19 <u>67</u> , to <u>August 1</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 1</u> , 19 <u>67</u> , and that death occurred at <u>255 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Newland E. Day</u>		22b. DATE SIGNED <u>August 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day M.D.</u>		22d. ADDRESS <u>4 E 33rd St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Aug 4, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR <u>Wm Cork-Beeks Towson</u>		25a. REC'D BY REGISTRAR <u>Aug 4 1967</u>	
ADDRESS <u>Towson, Md</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

10693

CENTINATE OF DEATH

Conte Hypocrite's Experiment  
Cassius M. Smith's Great Experiment

Robert's Great Experiment

Michael E. Day

4-2-33-12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
10694										
10695										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>707 Chumleigh Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>J. Huff Morrison</u>			4. DATE OF DEATH Month Day Year <u>August 13 1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Coa</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-28-13</u>		9. AGE (In years last birthday) <u>54</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sutton West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>W. Fletcher Morrison</u>					14. MOTHER'S MAIDEN NAME <u>NINA HUFF</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WW II 236-14-4965</u>		17. INFORMANT <u>MRS. ESTHER F. MORRISON</u>			Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of head of pancreas</u> (c) <u>Ascites 2° to 15b.</u>									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ascites 2° to 15b.</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from <u>25 July</u> , 1967, to <u>13 Aug</u> , 1967, that (I) (we) last saw the deceased alive on <u>13 Aug</u> , 1967, and that death occurred at <u>4:22 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>James Lawrence, III</u>					M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>13 Aug 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES LAWRENCE, III</u>					22d. ADDRESS <u>GREATER BALTO. MEDICAL CENTER</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-15-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>			23d. LOCATION (City, town or county) (State) <u>Pikesville Md</u>			
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u>					ADDRESS <u>6500 York Rd. 21212</u>		25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>			
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

1967

Baltimore

Washington

30 days

Great Baltimore Market, 107 South Street

Half Priced

White Case

Physician - Dr. J. Edgar Hoover

Dr. J. Edgar Hoover, 107 South Street

Yes, with some exceptions. For more information, please

contact the office of the Attorney General.

Enclosed for your information are the following

documents and reports.

Very truly yours,

John Edgar Hoover

Director, Federal Bureau of Investigation

U. S. Department of Justice

Washington, D. C. 20535

Enclosure

Aug 1 - 1967

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10695

10696

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
c. LENGTH OF STAY IN 1b <b>years</b>		d. STREET ADDRESS <b>113 Hedgewood Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>113 Hedgewood Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT HOLMES MUELLER</b>		4. DATE OF DEATH <b>August 26, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 9, 1923</b>
9. AGE (In years lost birthday) <b>44 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Room Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A. A. I.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Herbert Mueller, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Irene Amelia Cook</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. Two</b>		16. SOCIAL SECURITY NO. <b>219-18-6923</b>	
17. INFORMANT <b>Mrs. Doris J. Mueller, Same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19, 1962</b> , to <b>Aug 26, 1967</b> that (I) (we) last saw the deceased alive on <b>Aug 26, 1967</b> , and that death occurred at <b>2:45 AM</b> , from <b>causes</b> and on the date stated above.			
22a. SIGNATURE <b>Charles Mueller Jr</b>		22b. DATE SIGNED <b>August 26, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Herbert Mueller, Jr.</b>		22d. ADDRESS <b>Parkton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road</b>		25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>	
ADDRESS <b>Towson, Maryland 21204</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

<div>10696</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>Item #2 FilmG392 8/24/67</div> <div>CERTIFICATE OF DEATH</div> <div>10697</div>														
<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIDGEWAY MANOR CONV. HOME</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE (Baltimore)</u> d. STREET ADDRESS <u>4311 Joppa Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>SAMUEL</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>MUFFOLETTO</u> <u>AUG. 18 1967</u>			<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u>			<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>7-25-1892</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SHOE REPAIR</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ITALY</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				
<b>13. FATHER'S NAME</b> <u>P. MUFFOLETTO</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>YES</u> <u>WWI</u>						<b>16. SOCIAL SECURITY NO.</b> <u>217-38-6018</u>		<b>17. INFORMANT</b> <u>DANIEL MUFFOLETTO 4311 E. JOPPA RD</u> Address						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 7824 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)														
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)						
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1 am</u> <u>1967</u> to <u>18 Aug</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>13 Aug</u> <u>1967</u> , and that death occurred at <u>228 P</u> M, from the causes and on the date stated above.														
<b>22a. SIGNATURE</b> <u>William Goodman</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Aug 67</u>						
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>WILLIAM GOODMAN, MD</u>						<b>22d. ADDRESS</b> <u>1334 Sulphur Spring Rd - 21227</u>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>8-22-1967</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NEW CATHEDRAL CEM.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BALTO.</u> <u>MARYLAND</u>						
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edward J. Weber</u>						<b>ADDRESS</b> <u>WEBER FUNERAL HOME</u> <u>5311 EDMONDSON AVE</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 21 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>				

MEDICAL CERTIFICATION

10030

DEPARTMENT OF HEALTH

2

THE STATE OF NEW YORK  
IN SENATE  
January 12, 1911  
REPORT  
OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR  
1910  
ALBANY: J.B. LIPPINCOTT & CO. 1911



10697

## CERTIFICATE OF DEATH

10638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Baltimore</b>		c. LENGTH OF STAY IN 1b <b>Baltimore 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Armecost Nursing Home</b>		d. STREET ADDRESS <b>6689 Loch Hill Road</b>	
3. NAME OF DECEASED (Type or print) <b>PAUL C. MUGGE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1882.</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Sea Captain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Holland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Holland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>090-16-0042</b>	
17. INFORMANT <b>Mrs. Anita K. Barnes</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- AG CVD</b> DUE TO (b) <b>- myocardial infarct</b> DUE TO (c) <b>- pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> , 19 <b>67</b> , to <b>8-27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8-26</b> , 19 <b>67</b> and that death occurred at <b>9:00</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Alan Tapper</b>		22b. DATE SIGNED <b>8/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALAN TAPPER</b>		22d. ADDRESS <b>7501 York Rd</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Elkridge, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Baltimore

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Baltimore

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July 2, 1982

82

White

Male

100

Holland

United States

Unknown

Unknown

(Name)

Mr. Anita K. Hansen

000-123456

No

Albany, NY

Washington, D.C.

NYC

NYC

Leonard J. Cook, Inc., Baltimore, MD 21201

10698

## CERTIFICATE OF DEATH

10699

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u>				c. LENGTH OF STAY IN lb <u>WHITE MARSH</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BEL AIR RD BOX 686</u>				d. STREET ADDRESS <u>BOX 476 OLD PHIL. RD</u>			
3. NAME OF DECEASED (Type or print) <u>HELEN M. MULLEN</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>AUG. 15, 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CHARLES STANBURY</u>				14. MOTHER'S MAIDEN NAME <u>SARAH HEPDING</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS ARTHUR SCHULTZ</u> Address <u>BOX 686 KINGSVILLE</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary asphyxia</u> DUE TO <u>Ar. Pulmonary edema</u> DUE TO <u>Atherosclerotic heart dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 2 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Asphyxia; Embolism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/10 1967</u> , to <u>8/11 1967</u> , that (I) (we) last saw the deceased alive on <u>8/10 1967</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>J. Blatt</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. BLATT M.D.</u>				22d. ADDRESS <u>East, md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>				ADDRESS <u>300 MACE</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 16 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED OF DEATH

100301

750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10699		CERTIFICATE OF DEATH	
10700			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>		d. STREET ADDRESS <b>3101 Weaver Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1881.</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 Year Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Alexander Hall</b>		14. MOTHER'S MAIDEN NAME <b>Florida ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-144-5355</b>	
17. INFORMANT <b>Mr. Albert H. Hall, 5203 Falls Rd. Balto. Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach - metastasis</b> DUE TO (b) <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>August 18, 1967</b> to <b>August 21, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 18, 1967</b> , and that death occurred at <b>11:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. Allan Spier</b>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. Allan Spier</b>		22d. ADDRESS <b>Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/24/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

10088

DEPARTMENT OF HEALTH

Baltimore

Baltimore

Tolson

Baltimore

Chesapeake Labor Bureau Home

3101 Weaver Avenue

Female

White

Feb. 20, 1961

SS

Henrietta

Virginia

USA

Alexander Hall

Florida

SSO-44-255

No

Mr. Albert H. Hall, 2503 Wells St., Baltimore, Md.

A. Allan Jones

Baltimore, Md.

Initial

6/21/61, Baltimore Cemetery

Baltimore, Md.

Lawrence J. Hall, Inc., Baltimore, Md. 21214



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

10700

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 10701

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>				c. LENGTH OF STAY IN 1b <u>20 YEARS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1748 GORDON AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CATHERINE</u> Last <u>NAUMANN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1968</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 7, 1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		9. AGE (In years last birthday) <u>85</u> yrs.		11. BIRTHPLACE (County & State, or foreign country) <u>PITTSBURG, PA.</u>	
13. FATHER'S NAME <u>HENRY HOTEM</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-54-5909</u>		17. INFORMANT Address <u>BALTO. 21207 MO.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL APOPLEXY</u> 334X DUE TO (b) <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>11 DAYS</u> <u>15 YEARS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15, 1950</u> , to <u>AUGUST 19, 1967</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>AUGUST 18, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin L. Pierpont</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>				22d. ADDRESS <u>8204 LIBERTY RD - BALTO. 21207 MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		23d. LOCATION (City, town or county) (State) <u>BALTO., MD.</u>	
24. FUNERAL DIRECTOR <u>Garth Miller - 2334 Jefferson St.</u>				25a. REC'D BY REGISTRAR <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

10700

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Bureau" and "Office" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10701 CERTIFICATE OF DEATH 10702											
1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 185</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>Box 185</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Andrew Jackson Naylor</b>						4. DATE OF DEATH Month <b>Aug.</b> Day <b>27,</b> Year <b>19 67</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 25, 1887</b>		9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>State Road</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Balto. Co. Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Thomas L. Naylor</b>						14. MOTHER'S MAIDEN NAME <b>Elizabeth A. Curtis</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-12-2917</b>		17. INFORMANT Address <b>Mrs. Ada M. Naylor Box 185 Reisterstown, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Primary Carcinoma of Colon</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part f or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 29, 1966</b> to <b>Aug. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>8/24</b> , 19 <b>67</b> , and that death occurred at <b>1967</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Joseph E. Bush</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Joseph E. Bush, M.D.</b>						22b. DATE SIGNED <b>8/28/67</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Hampstead Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Aug. 30, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Upperco, Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tipton - Eline Funeral Home Hampstead, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR <b>AUG 30 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10702

## CERTIFICATE OF DEATH

10703

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>5 months</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>			d. STREET ADDRESS <b>3600 West Belvedere Ave.</b>		
3. NAME OF DECEASED (Type or print) First <b>Marcellus</b> Middle <b>-</b> Last <b>NELSON</b>			4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-66</b>	9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>16</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Cty, Md.</b>	
13. FATHER'S NAME <b>Raymond Read</b>			14. MOTHER'S MAIDEN NAME <b>Barbara Jackson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> <b>344X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH. <b>17 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (X) (this hospital) attended the deceased from <b>3/6</b> , 19 <b>67</b> , to <b>8/16</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>8/16</b> , 19 <b>67</b> , and that death occurred at <b>3:45</b> A.M., from causes and on the date stated above.					
22a. SIGNATURE <b>Philip Zieve</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/16/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Philip Zieve, M.D.</b>			22d. ADDRESS <b>Rosewood St. Hosp., Owings Mills, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>8/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johns Hopkins School of Med.</b>		23d. LOCATION (City or Town) (County) (State) <b>709 N. Wolfe, Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Newell Funeral Home Baltimore - 8-224</b>			25a. REC'D BY REGISTRAR <b>AUG 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2870



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10703

CERTIFICATE OF DEATH

10704

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville Baltimore Co.</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Shady Nook Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mary Halethorpe</b> d. STREET ADDRESS <b>5549 Oregon Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM L. NETHKEN</b> First Middle Last 4. DATE OF DEATH <b>August 25, 1967</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>July 15, 1879</b> 9. AGE (In years last birthday) <b>88</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Supervisor</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles O. Nethken</b> 14. MOTHER'S MAIDEN NAME <b>Ada Best</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>705-07-4943A</b> 17. INFORMANT <b>Miss Carrie H. Nethken, 5549 Oregon Ave.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Congestive Failure</b> DUE TO (b) <b>Arterio Sclerotic Cardiovascular Disease</b> stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>July, 1957</b> , to <b>8/25, 1967</b> , that (I) (we) last saw the deceased alive on <b>8/25, 1967</b> , and that death occurred at <b>9:13 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>J. N. Frederick MD</b> 22c. PHYSICIAN'S NAME (Type) <b>J. N. Frederick MD</b> 22d. ADDRESS <b>1311 Francis Ave. 21227</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>8/25/67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 23b. DATE THEREOF <b>8-28-1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Howard County, Maryland</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave.</b> 25a. REC'D BY REGISTRAR <b>AUG 28 1967</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10713

Refiners

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Shady Hook Refining Co.

Refiners Co.

Shady Hook Refining Co.

12-13 Oregon Ave.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10704

CERTIFICATE OF DEATH

10705

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>1926 MERRITT BLVD.</b>	
3. NAME OF DECEASED (Type or print) <b>ALSO: MICHAEL</b> Middle <b>---</b> Last <b>NIKONCHUK NICHOLS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/05</b>
9. AGE (In years and months) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS &amp; ELECTRIC CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>ALEXANDRIA MN: UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>212 05 45 85</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STAPHYLOCOCCAL PNEUMONIA, BILATERAL</b> DUE TO <b>201X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>STAPHYLOCOCCAL ABSCESS, PRE SACRAL AREA</b> DUE TO <b>3 DAYS</b> (c) <b>LYMPHOMA (HODGKINS)</b> <b>? 3 DAYS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CEREBRAL ARTERIOSCLEROSIS; CHRONIC PYELONEPHRITIS; ADRENAL CORTICAL</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II) <b>STEROID THERAPY.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>7/27/67</b> , 19 <b>67</b> , to <b>8/7/67</b> , 19 <b>67</b> , that <del>he</del> (we) last saw the deceased alive on <b>8/7/67</b> , 19 <b>67</b> , and that death occurred at <b>4:10AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Neilson Neilson</b>		22b. DATE SIGNED <b>8/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>AUG 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>GERMAN HILL RD. BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>Joseph N. Zannino Funeral Home</b>		25a. REC'D BY REGISTRAR <b>8</b>	
ADDRESS <b>257 S. Conkling St. Baltimore, Md.</b>		DATE <b>AUG 10 1967</b>	

1000

CERTIFICATE OF DEATH

BALTIMORE

BALTIMORE

JOHN HOWARD

IT LAY

BALTIMORE - MISS

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MICHAEL

MICHAEL  
MICHAEL

MALE

WHITE

1880

LABORER

ONE & HALF PER CENT

UNKNOWN

YES

WM I

SIR OF THE CITY OF BALTIMORE, IN RESPONSE, AT BALTIMORE, MD.

3 DAYS

EMERGENCY, BALTIMORE

3 DAYS

BALTIMORE, THE BALTIMORE

(BALTIMORE)

CERTIFICATE OF DEATH, THIS IS THE FIRST OF THE BALTIMORE, MD.

1880

1880

1880

AT BALTIMORE, MD.

AT BALTIMORE, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1247 LEEDS TERRACE</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ARBUTUS</b> d. STREET ADDRESS <b>1247 LEEDS TERRACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>NINA</b> Middle <b>MAY</b> Last <b>NOLAN</b>			4. DATE OF DEATH Month <b>AUG.</b> Day <b>10</b> Year <b>1967</b>						
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 19, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William W. Adams</b>					14. MOTHER'S MAIDEN NAME <b>Minnie</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-30-5590</b>		17. INFORMANT <b>Mr Helen Taggart - 1247 Leeds Terrace</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOPATHY</b> <b>4221</b> DUE TO <b>CUTANEOUS DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 YEARS</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> , 19 <b>67</b> , to <b>8/11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/10</b> , 19 <b>67</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Phyllis E. Clark</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/11/67</b>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR <b>Farley Cronan</b> ADDRESS <b>2701 Catonsville, Md.</b>					25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1552



10706

## CERTIFICATE OF DEATH

10707

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN lb <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BAPTIST HOME OF MARYLAND</b>		d. STREET ADDRESS <b>8606 SUMMIT AVE.</b>	
3. NAME OF DECEASED (Type or print) <b>MAE FREDRICKA NORRIS</b>		4. DATE OF DEATH <b>AUGUST 2 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 13, 1883</b>
9. AGE (In years lost birthday) yrs. <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FREDERICK KORN</b>		14. MOTHER'S MAIDEN NAME <b>CHRISTINA JUDD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>BAPTIST HOME OF MD. OWINGS MILLS, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Sclerosis</b> DUE TO <b>Arterio Sclerotic Cardio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Vascular Disease</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL-DISEASE CONDITION GIVEN IN PART I(o) <b>Semipalm</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 2 1967</b> to <b>Aug 2 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug 2 1967</b> , and that death occurred at <b>4:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>DR. M. PAUL BYERLY</b>		22b. DATE SIGNED <b>8/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. M. PAUL BYERLY</b>		22d. ADDRESS <b>5820 YORK RD, BALTIMORE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-5-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MD.</b>
24. FUNERAL DIRECTOR <b>MITCHELL-WIEDEFELD HOME, INC.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

10707

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10708

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21201 21212</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>521 Rossiter Ave.</b> <del>2200 Rossiter Ave.</del>	
3. NAME OF DECEASED (Type or print) <b>William Robert</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> <del>XXXXXXX</del> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1943</b>
9. AGE (In years lost birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>24</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert C. Null</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth N. Stine</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-04-3056</b>	
17. INFORMANT <b>Robert C. Null</b>		Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8214 Brain Stem Damage</b> IMMEDIATE CAUSE (a) <b>From Head Injury</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>37 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Thrown To Road from Front RT Seat of Volkswagen</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>August 22 1967</b> p.m.		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Towson #4 Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>		22. DATE SIGNED <b>8/24/67</b>	
23a. BURIAL, CREMATION, or OTHER (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10708

10709

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21214</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21214</b> d. STREET ADDRESS <b>2702 Bayonne Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Perry</b> First <b>V.</b> Middle <b>OGLE</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>2,</b> Year <b>1967</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1892</b>	9. AGE (In years lost birthday) <b>75</b> yrs.	10. IF UNDER 1 YEAR Months <b>75</b>	11. IF UNDER 24 HRS. Days <b>75</b>	12. IF UNDER 24 HRS. Hours <b>75</b>	13. IF UNDER 24 HRS. Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired Carpenter Foreman</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Samuel V. Ogle</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-7646</b>		17. INFORMANT <b>Mrs. Olive R. Ogle</b> Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/28/</b> , 19 <b>67</b> , to <b>8/2/</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/2/</b> , 19 <b>67</b> , and that death occurred at <b>8 A.M.</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Beatriz P. Dizon</b>		22b. DATE SIGNED <b>August 1, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Beatriz P. Dizon, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/67.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		23e. REC'D BY REGISTRAR <b>DATE AUG 2 1967</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		24a. ADDRESS <b>21214</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24d. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Agency: Rock Inc. Date: 10/21/10

10. 11. 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the organ papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10709

10710

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE CITY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN lb <b>12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 30-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>2813 BEECHLAND AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MISS. CHARLOTTE PALM</b> First Middle Last				4. DATE OF DEATH <b>AUG. 1, 1967</b> Month Day Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-7-1881</b> 86 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>JOHN PALM</b>				14. MOTHER'S MAIDEN NAME <b>MARGARENE SPANIOL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-54-1881</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. IMMEDIATE CAUSE (a) <b>Diffuse Pulmonary Fibrosis</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>0021</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchiectasis, Tuberculosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-19, 1967</b> , to <b>8-1, 1967</b> , that (I) (we) last saw the deceased alive on <b>8-1, 1967</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>W Newcomer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>				22d. ADDRESS <b>Mt. Wilson State Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8 4 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		23d. LOCATION (City or Town) (County) (State) <b>Brooklyn, A. A. CO. Md.</b>	
24. FUNERAL DIRECTOR <b>Mc Gully</b>				ADDRESS <b>130 E. Fort Ave</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 3 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>J Charles Jones</b>			

10702

Dr. Wilson

Dr. Wilson

Dr. Wilson

Dr. Wilson

Dr. Wilson

FOR STATE  
HEALTH DEPT.

10710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10711

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore Towson</b> c. LENGTH OF STAY IN 1b <b>30.4</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3802 Kimble Road</b> <b>KIMBLE ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN Marion PANUSKA</b>		4. DATE OF DEATH Month Day Year <b>August 13 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1900</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Cleveland, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Chadema</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>295-03-6151</b>	
17. INFORMANT <b>Frank J. Panuska, Jr.</b>		Address <b>Whiteford, Md. Deep Run Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>8254</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto that went through a stop sign</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:50 p.m. 8 13 19 67</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) (County) (State) <b>Baltimore, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b> EXAMINER'S NAME (Type) <b>WERNER U. SPITZ, M.D.</b>		22. DATE SIGNED <b>8-14-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/16/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Grds.</b>	23d. LOCATION (City or Town) (County) (State) <b>Belair Md.</b>
24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Rd. Balto. 12, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 16 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10711

CERTIFICATE OF DEATH

10712

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>			d. STREET ADDRESS <b>629 N. SCHROEDER STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH DANIEL PARKER</b>			4. DATE OF DEATH Month Day Year <b>AUGUST 2 19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/12/92</b>	9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITALS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GREENVILLE, N. C.</b>	
13. FATHER'S NAME <b>NATHAN PARKER</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>			16. SOCIAL SECURITY NO. <b>215 05 45 44</b>		
17. INFORMANT <b>VA HOSPITAL FORTHOWARD, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DIVERTICULITIS LEFT COLON, BLEEDING</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN DEATH AND DEATH WEEK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE GANGRENE RIGHT FOOT</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 24, 1967</b> , to <b>AUGUST 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 2, 1967</b> , and that death occurred on <b>11:15 PM</b> from causes and on the date stated above.					
22a. SIGNATURE <i>George MacElPatrick</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>AUGUST 3, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>GEORGE MAC ELPATRICK</b>			22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-7-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>ARBUTUS MARYLAND</b>		
24. FUNERAL DIRECTOR <b>CHARLES R. LAW</b>			25a. REC'D BY REGISTRAR <b>DATE AUG 4 1967</b>		
ADDRESS <b>802 MADISON AVE BALTO MD.</b>			25b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i>		

MEDICAL CERTIFICATION

1001

NAME

DATE

ADDRESS

PHYSICIAN

DR. H. SCHMIDT, DENTIST

VERMONT ADULTS' HOSPITAL

AGE

SEX

RELIGION

EDUCATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10712

CERTIFICATE OF DEATH

10713

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3421 Birch Hollow Road</u>				d. STREET ADDRESS <u>3421 Birch Hollow Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>Jay</u> Last <u>Pateka</u>				4. DATE OF DEATH <u>August 6, 1967</u> Month <u>August</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1952</u>	9. AGE (In years last birthday) <u>14</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isadore Pateka</u>				14. MOTHER'S MAIDEN NAME <u>Anna Pfeffer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mr. Isadore Pateka, 3421 Birch Hollow Road</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolus</u> DUE TO <u>Severe congenital cardiac disease</u> (b) <u>(Aortic stenosis)</u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1967</u> to <u>Aug. 6, 1967</u> , that (I) (we) lost the deceased alive on <u>July 13, 1967</u> , and that death occurred at <u>5:30 P.M.</u> from causes on and on the date stated above.							
22a. SIGNATURE <u>Samuel S. Glick</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel Shippley Glick</u>				22d. ADDRESS <u>3914 Park Heights Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Belington)</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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1248 J. L. D. Brown et al.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Items #8, 9 & 12 Film#G392 8/28/67 ph

10713

CERTIFICATE OF DEATH

10714

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>a.e.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Black &amp; N Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home - 5426 Whitlock Road</u>				d. STREET ADDRESS <u>108 W. 11<sup>th</sup> Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE K. PATRICK (PETRYK)</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1897</u>	9. AGE (In years last birthday) yrs. <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA-HUNGARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>V. KONDRUSKA</u>				14. MOTHER'S MAIDEN NAME <u>D.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-1313</u>		17. INFORMANT <u>Fam. / 1 -</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD - severe.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <u>A.R. Sosnowski</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>8/23/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>A.R. Sosnowski</u>				22d. ADDRESS <u>4016 Ritchie Hwy Balto. 25. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>AUG. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto. Md. MD</u>				
24. FUNERAL DIRECTOR <u>John H. Nahn</u> <u>4200 Pennington Ave</u> <u>Baltimore 21226, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

RECEIVED

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

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10714  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item #8 Film #G392 8/28/67 ph  
CERTIFICATE OF DEATH  
10715

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>3808 OLD FREDERICK ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>BENTON</b> Middle <b>-</b> Last <b>PEGRAM</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>20</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/15/1899</b> AGE (In years last birthday) <b>77</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ORDERLY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>HOLLY SPRINGS, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSIE PEGRAM</b>		14. MOTHER'S MAIDEN NAME <b>DELLIE SPENCE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>240 20 05 08</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>491X</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA PANCREAS WITH DIABETES MELLITUS</b> (c) <b>METASTATIC CARCINOMA REGIONAL LYMPH NODES AND LIVER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE. BENIGN PROSTATIC HYPERTROPHY</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>8/10/67</b> , 19__, to <b>8/20/67</b> , 19__, that <del>we</del> (we) last saw the deceased alive on <b>8/20/67</b> , 19__, and that death occurred at <b>2:40AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>J. Fabara</i>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-24-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		25. REC'D BY REGISTRAR <b>WILSON FUNERAL HOME</b> <b>ORLEANS STREET, BALTIMORE, MD.</b>	

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To be countersigned by Dr. Chas. P. O'Donn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10715

10716

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>30-4</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>313 E. Melrose Avenue #21212</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grace E. Perego</b> 4. DATE OF DEATH <b>August 1, 1967</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 4, 1888</b> 9. AGE (In years lost birthday) <b>79</b> yrs.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William H. Stuart</b> 14. MOTHER'S MAIDEN NAME <b>Sarah E. Poston</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>217-01-7593B</b> 17. INFORMANT <b>Walter Perego (Husband)</b> Address <b>Same</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION, ACUTE</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>Fracture of R Ankle</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>July 29, 1967</b> , to <b>August 1, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 1, 1967</b> , and that death occurred at <b>2:10 AM</b> from causes and on the date stated above. 22a. SIGNATURE <b>Frederick J. Vellmer</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>August 1, 1967</b> 22c. PHYSICIAN'S NAME (Type) <b>Frederick J. Vellmer</b> 22d. ADDRESS <b>6100 York Road</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Aug. 3, 1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		24. FUNERAL DIRECTOR <b>Eugenia K. Seitz</b> ADDRESS <b>5209 York Road</b> <b>Seitz Funeral Home Baltimore, Md. 21212</b> 25a. REGD. BY REGISTRAR <b>AUG 3 1967</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

Approved for Medical Examiner  
by  
Medical Examiner  
J. Charles Judge

6151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10716

CERTIFICATE OF DEATH

10717

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>	
c. LENGTH OF STAY IN 1b <u>YRS</u>		d. STREET ADDRESS <u>242 Ashland Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>242 Ashland Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Kinsey Perry Sr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23 1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WHICH MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benjamin F. Perry</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH TURNBAUGH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>721-18-3613</u>	
17. INFORMANT <u>MR. EVA R. PERRY</u>		Address <u>- Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO <u>arteriosclerosis</u> (c) <u>Peripheral coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> , 19 <u>40</u> , to <u>8-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-9-</u> 19 <u>67</u> , and that death occurred at <u>9:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>James B. Saffell MD</u>		22b. DATE SIGNED <u>8-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James B. Saffell MD</u>		22d. ADDRESS <u>Restonstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Aug. 14 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jesson</u>	23d. LOCATION (City or Town) (County) (State) <u>Sparks, Md.</u>
24. FUNERAL DIRECTOR <u>Wm Cook - Brooks Towson, Towson, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1971



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 10/57

10717

# CERTIFICATE OF DEATH

Reg. Dist. No.

10718

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mercy Villa</b>		d. STREET ADDRESS <b>501 Anneslie Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b> First <b>Agnes</b> Middle <b>Peters</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 18, 1873</b>
9. AGE (In years last birthday) <b>94</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Freeland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Stinefelt</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-56-7050</b>	
17. INFORMANT <b>Sister M. Carlotta, R.S.M.</b>		Address <b>Mercy Villa 6400 Bellona Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic Cardio-Vascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4221</b> DUE TO (c) <b>4221</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1965</b> , to <b>August 4, 1967</b> , that I last saw the deceased alive on <b>July 29, 1967</b> , and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip D. Flynn</b>		M.D. <b>4 E. Chase St. Baltimore Md. 21202</b>	
PHYSICIAN'S NAME (Type) <b>Philip D. Flynn, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/7/67</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Tichner &amp; Sons</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 8 1967</b>	
24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

# CERTIFICATE OF DEATH

1977

WILLIAM BOLM

CONFIDENTIAL

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10719

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN lb <b>Baltimore-27</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>728 Warwick Rd. 21229</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-27</b>	
3. NAME OF DECEASED (Type or print) <b>John W. Pfeifer</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1895</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Tool &amp; Die Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Pfeifer</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Kemp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-3406</b>	
17. INFORMANT <b>Mrs. Anna C. Pfeifer, 728 Warwick Rd., Balto 7</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1992 Generalized Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>none 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>8-2-67</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/5/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave., Balto. 29</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10719

## CERTIFICATE OF DEATH

10720

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>XXXXXXXXXX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 21218	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cheasapeake Manor Nursing Home</u>		d. STREET ADDRESS <u>1317 North View Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Pfeil</u> Last <u>Pfeil</u>		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-1896</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General Mgr. Coal &amp; Grain Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Pfeil</u>		14. MOTHER'S MAIDEN NAME <u>Margaret ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW1</u>		16. SOCIAL SECURITY NO. <u>WW1</u>	
17. INFORMANT <u>Mrs. Elizabeth Pfeil</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder - metastasis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> to <u>August 4, 1967</u> , that (I) <u>was</u> saw the deceased alive on <u>August 4, 1967</u> , and that death occurred at <u>6:00 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A. Allan Spier</u>		22b. DATE SIGNED <u>8/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. Allan Spier</u>		22d. ADDRESS <u>Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/26/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10718

STATEMENT OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BOSTON, MASS.

For use by

81218

1911 XXXXXXX

USA

England

Residence of Deceased at Death

Married

Charles F. Hall

(See No.)

Mrs. Elizabeth Hall

Yes



A. Allen Baker

Baltimore, Md.

Deceased's Cemetery

Baltimore, Md.

8/2/11

Burial

Interment in Public Burial Ground

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10720 CERTIFICATE OF DEATH 10722

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>Life long</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Baltimore Medical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3511 White Ave. Baltimore, Md. 304</b> d. STREET ADDRESS <b>3511 White Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Ethel Phillips</b> First Middle Last		4. DATE OF DEATH <b>August 11 1967</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Can.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1904 9-30</b> 9. AGE (In years last birthday) <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Elvie Bennington</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>June Gallack (daughter)</b>	
17. INFORMANT <b>Same wife deceased</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Cervical Carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 26, 1967</b> to <b>August 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 11 1967</b> , and that death occurred at <b>12</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Shen-Sho Tseang</b>			
22b. DATE SIGNED <b>8-11-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>SHEN-SHO TSEANG, M.D.</b>			
22d. ADDRESS <b>Greater Baltimore Medical Center</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/14/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		25a. REC'D BY REGISTRAR <b>AUG 11 1967</b>	
ADDRESS <b>Balto. Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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10721

Item #1d Film #0392 9/11/67 ph

CERTIFICATE OF DEATH

10721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn, N.Y.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing House in the Pines home</u>		d. STREET ADDRESS <u>214 Albermarle Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Phillips</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13. FATHER'S NAME <u>Samuel Richard Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Magdaline Kiefer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Disorganization</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u> <u>1037</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u>		(County) <u>—</u>
20g. (State) <u>—</u>		(State) <u>—</u>
21. I certify that I attended the deceased from <u>8-23</u> , 1967, to <u>8-28</u> , 1967, that I last saw the deceased alive on <u>8-26</u> , 1967, and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>6-22-67 Frederick K. Ave</u>
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Baltimore, 22225 Md.</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/31/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>
22d. LOCATION (City, town, or county) <u>Flushing, N.Y.</u>		(State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Fuld</u>		24a. REC'D BY REGISTRAR <u>SEP 1</u>
ADDRESS <u>4781 Bonnie Brae</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>

CERTIFICATE OF DEATH

1077

THE DECEASED

NAME OF DECEASED: *Richard Philip Hagadone*

AGE: *21* SEX: *M*

DATE OF DEATH: *Jan 23 1946*

TIME OF DEATH: *8:45 AM*

PLACE OF DEATH: *New York*

CAUSE OF DEATH: *Heart Disease*

DIAGNOSIS: *Myocardial Infarction*

DATE OF BIRTH: *Jan 2 1925*

PLACE OF BIRTH: *New York*

EDUCATION: *High School*

OCCUPATION: *Student*

RELIGION: *Catholic*

DATE OF INTERMENT: *Jan 24 1946*

PLACE OF INTERMENT: *New York*

DATE OF BURIAL: *Jan 24 1946*

PLACE OF BURIAL: *New York*

DATE OF CREMATION: *Jan 24 1946*

PLACE OF CREMATION: *New York*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

VR A15ME (5)  
6M 1/67

10722

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10723

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>03/1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>621 St. Francis Road</u>		d. STREET ADDRESS <u>621 St. Francis Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Piccinini</u> Last <u>Piccinini</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1896</u>
9. AGE (In years last birthday) yrs. <u>71</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Antonio Laudi</u>		14. MOTHER'S MAIDEN NAME <u>Eugenia Bruni</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>24-388983</u>	
17. INFORMANT <u>Mr. Anthony Piccinini</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> last. (c) <u>57 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u>		22. DATE SIGNED <u>8/5/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>8/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10723

10724

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN lb <b>7 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2207 Lynbrook Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>FRANK NMI PICKENS</b>		First Middle Last		4. DATE OF DEATH <b>August 27 1967</b>		Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 3, 1927</b>		9. AGE (In years last birthday) yrs. <b>40</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Box Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia, Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>HERBERT PICKENS</b>			14. MOTHER'S MAIDEN NAME <b>LULA WILLIAMS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>216 16 09 92</b>		17. INFORMANT <b>Clinical Records, VA Hospital, Ft Howard, Md</b>			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810 HEPATIC COMA DUE TO NUTRITIONAL CIRRHOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>PARALYTIC ILEUS SECONDARY TO HYPOKALEMIA</b> (c) <b>8 DAYS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>9 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>(x)</b> (this hospital), attended the deceased from <b>8/20/67</b> , 19__, to <b>8/27/67</b> , 19__, that <b>(x)</b> (we) lost saw the deceased alive on <b>8/27/67</b> , 19__, and that death occurred on <b>8/27/67</b> , 19__, at <b>4:45 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Rodolfo G. Mero, M.D.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/28/67</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>			
23a. BURIAL (Cremation, Removal, Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/31/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR <b>HAILESTAD FUNERAL HOME</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judgen</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10724

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>133 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. STREET ADDRESS <b>6437 HARTWATT STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CECIL A. POMEROY, SR.</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 23 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/93</b>
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FOREMAN CROWN, CORK &amp; SEAL CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>VALLEY LEE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES H. POMEROY</b>		14. MOTHER'S MAIDEN NAME <b>RUTH CLEMENTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213 01 67 21</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CACHEXIA AND ANEMIA PROBABLY SECONDARY TO #1</b> (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/12/67</b> , 19__ to <b>8/23/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/23/67</b> , 19__, and that death occurred <b>12:00 Noon</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Howard G. Kramer</i>		22b. DATE SIGNED <b>8/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>HOWARD G. KRAMER, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTO. CO. MD</b>
24. FUNERAL DIRECTOR <i>Walter Brooks Bradley</i>		25a. REC'D BY REGISTRAR <b>WALTER BROOKS BRADLEY</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <b>WILLOW SPRING ROAD, BALTIMORE, MD.</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>16</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Towson)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>58 St. Joseph Hospital</b>		d. STREET ADDRESS <b>3514 E. Joppa Road #21234</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edna Claire Preisinger</b>		4. DATE OF DEATH Month Day Year <b>August 20 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1907</b>
9. AGE (In years lost birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Volker.</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Corner.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-16-5006</b>	
17. INFORMANT <b>Margaret Wassenus, 3514 E. Joppa Rd.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } <b>diffuse pulmonary fibrosis.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <b>August 19, 1967</b> , to <b>August 20, 1967</b> that (H) (we) last saw the deceased alive on <b>August 20, 1967</b> , and that death occurred at <b>12:40 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M.D.</b>		22b. DATE SIGNED <b>August 20, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>		22d. ADDRESS <b>7620 York Road, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>	23b. DATE THEREOF <b>8/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, inc. 5305 Harford Rd.</b>		25a. REC'D BY REGISTRAR <b>AUG 22 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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10726

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10727

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>21206</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21206</b> d. STREET ADDRESS <b>5910 Starleigh Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EMMA E. PRESSON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1900</b>
9. AGE (In years lost birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>19</b> Hours <b>67</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Telephone Oper. Telephone</b>		12. 10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	
13. FATHER'S NAME <b>John B. Neal</b>		14. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. SOCIAL SECURITY NO. <b>212-05-0291</b>		18. MOTHER'S MAIDEN NAME <b>Susan Howard</b>	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		20. INFORMANT Address <b>Mrs. Mary Turc, 5910 Starleigh Road</b>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: <b>5870</b> IMMEDIATE CAUSE (a) <b>Acute hemorrhagic pancreatitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute myocardial infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute myocardial infarction</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 16, 1967</b> , to <b>August 17, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 17, 1967</b> , and that death occurred at <b>1:00 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>August 17, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City or Town) (County) (State) <b>Elkridge, Md.</b>	
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home 4210 Belair Road.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10727

CERTIFICATE OF DEATH

10728

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. LENGTH OF STAY IN 1b <b>11½ months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>		d. STREET ADDRESS <b>1311 Glenwood Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Howard PRESTON</b>		4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-20-52</b>
9. AGE (In years lost birthday) <b>14</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emmert Howard Preston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Cecelia Schanberger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Rosewood Records, Owings Mills, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> DUE TO (b) <b>Severe brain contusion</b> DUE TO (c) <b>Car accident</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Child was struck by truck while riding a bicycle</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>June 19 1967</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from <b>8-30</b> , 19 <b>66</b> , to <b>8-17</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>8-17</b> , 19 <b>67</b> , and that death occurred at <b>9:25 A.M.</b> on causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>8/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rosewood State Hospital</b>		22d. ADDRESS <b>Rosewood State Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/21/67.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL CEM.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR <b>AUG 18 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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STATE OF MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10728 CERTIFICATE OF DEATH 10729

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY in b <b>11 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Balto. Medical Center</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>Hopkins Apts. #601</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <b>ORA</b> Middle <b>MAY</b> Last <b>Price</b>		4. DATE OF DEATH Month <b>8</b> Day <b>7</b> Year <b>1967</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>CAU.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-24-93</b>		9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(RET.) BOOKKEEPER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Curtis Price</b>				14. MOTHER'S MAIDEN NAME <b>Marie Estelle Stone</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-07-5807</b>				17. INFORMANT <b>SELF MRS. CATHERINE HERMANN</b> Address <b>4712 HAZELWOOD AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2001 Cardio-respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized lymphosarcoma &amp; Diabetes</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>																INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7.28i</b> <b>1967</b> , to <b>8.7.</b> <b>1967</b> , that (I) (we) last saw the deceased alive on <b>8.7. 5:45 PM 1967</b> , and that death occurred at <b>7:45 P.M.</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Ret. M. Bassi</b>																			
22c. PHYSICIAN'S NAME (Type) <b>DR. BRANTIGAN</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>8-7-67</b>				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/12/67</b>				23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>							
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd.</b>								25a. REC'D BY REGISTRAR <b>AUG 10 1967</b>				25b. REGISTRAR'S SIGNATURE <i>John A. Judge</i>							

DR. BRANTIGAN

8-2-61

312-012801

SELF

NO

John Curtis Price

Marie Estelle Stone

NA

Baltimore

Female CAN

8-24-23

ORA

MAY

Price

8

7

Greater Baltimore Medical Center Hopkins Apts #601

11 days

Baltimore

Baltimore

M/9

CERTIFICATE OF DEATH

10729

10730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr2mth10dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>E.</b> Last <b>Proctor</b>		4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1921</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Joseph</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Obesity</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Obesity</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>June 11, 1965</b> to <b>Aug. 21, 1967</b> that (X) (we) lost saw the deceased alive on <b>Aug. 21, 1967</b> , and that death occurred at <b>7:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED <b>8-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 25/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Resurrect. Co.</b>	23d. LOCATION (City or Town) (County) (State) <b>Clinton, Md.</b>
24. FUNERAL DIRECTOR <b>Martell Adams</b>		25. FILED BY REGISTRAR <b>Aug 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>James J. Adams</i>			

1978

OFFICE OF DEATH

Death Date: 10/10/78  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Race: [illegible]  
Birth Date: [illegible]  
Birth Place: [illegible]  
Cause of Death: [illegible]  
Manner of Death: [illegible]  
Place of Death: [illegible]  
Time of Death: [illegible]  
Signature: [illegible]  
Date: [illegible]

Order: [illegible]  
Remarks: [illegible]  
Signature: [illegible]  
Date: [illegible]

Signature: [illegible]  
Date: [illegible]  
Remarks: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10730

CERTIFICATE OF DEATH

10731

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>50yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>6101 Loch Raven Blvd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St Joseph Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Adele</b> Last <b>Propf</b>		4. DATE OF DEATH Month <b>8</b> Day <b>26</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/17/1898</b>
9. AGE (In years last birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Long</b>		14. MOTHER'S MAIDEN NAME <b>—</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-20-6754</b>	
17. INFORMANT <b>Mr. John T. Propf-6028 Chesworth Rd-28</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b> 331 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) (County) (State) <b>—</b>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/26/1967</b> , to <b>8/26/1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/26/1967</b> , and that death occurred at <b>10p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>August 27, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>St. Joseph Hospital Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/29/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Maria Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Towson Balto. Co.</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd 21212</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>—</b>	

100-30

RECEIVED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 60322

DATE 10/10/00 BY 60322

100-30

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10731

## CERTIFICATE OF DEATH

10732

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dulaney Towson Nursing Home</u>				d. STREET ADDRESS <u>2317 Linden Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CELIA</u> Middle <u>PUGATCH</u> Last <u>—</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>8</u> Year <u>19 67</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>65</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Selig Luboff</u>				14. MOTHER'S MAIDEN NAME <u>Chiah ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-48-8654</u>			
17. INFORMANT <u>Mr. Melvin Pugatch, 3715 Seven Mile Lane</u>				Address <u>#8</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> <u>200X</u> DUE TO <u>Acute massive myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO <u>Diabetes mellitus</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>65</u> , to <u>Aug 8</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>67</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5501 Park Heights N. Baltimore MD</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>William D Appleford</u>				M.D. <u>—</u>			
PHYSICIAN'S NAME (Type) <u>William D Appleford</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Workman Circle</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson &amp; Bros., Inc., 6010 Reist., Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

CERTIFICATE OF DEATH

Reg. No. 10

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>	
<p>SEX <i>Male</i></p>		<p>RACE <i>White</i></p>	
<p>DATE OF BIRTH <i>Jan 15 1900</i></p>		<p>PLACE OF BIRTH <i>Baltimore, Md.</i></p>	
<p>DATE OF DEATH <i>Jan 20 1945</i></p>		<p>PLACE OF DEATH <i>Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PERMANENT CAUSE <i>Coronary Artery Disease</i></p>		<p>INTERMEDIATE CAUSE <i>Thrombosis</i></p>	
<p>PRE-EXISTING DISEASES <i>Hypertension</i></p>		<p>PRE-EXISTING CONDITIONS <i>None</i></p>	
<p>DATE OF EXAMINATION <i>Jan 21 1945</i></p>		<p>PLACE OF EXAMINATION <i>Baltimore, Md.</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe</i></p>	
<p>DATE OF REGISTRATION <i>Jan 21 1945</i></p>		<p>PLACE OF REGISTRATION <i>Baltimore, Md.</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~renew~~ renew carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10732

CERTIFICATE OF DEATH

10733

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN Tb <b>4 yrs, 3 mos</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2533 Greenmount Ave.,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HILDA FAYE RAMSAY</b>		4. DATE OF DEATH Month <b>8</b> - Day <b>16</b> - Year <b>1967</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/1912</b>
9. AGE (In years lost birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waitress</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wilbrin Hazlett</b>		14. MOTHER'S MAIDEN NAME <b>Faye Hughes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>035-14-7036</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor pulmonale</b> DUE TO (b) <b>Far advanced, pulmonary Tb, active</b> DUE TO (c) <b>4 years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>one year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic peptic ulcer in stomach</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/20/</b> , 19 <b>63</b> , to <b>8/16/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/16/</b> 19 <b>67</b> , and that death occurred at <b>4:50AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>8/18/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem. Inc.</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road 21212</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			

10703

UNITED STATES

10703

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10733

CERTIFICATE OF DEATH

10734

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN <b>16</b> days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greater Balt. Medical Center</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY NELSON</b> (OR) <b>HARRY NELSON</b> Middle Last <b>RAY</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-12-11</b> 9. AGE (In years, lost birthday) <b>56</b> Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photo. Engraver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. News &amp; Amer.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Harry Francis Ray</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-4312</b>	
17. INFORMANT <b>Mrs. Dolores M. Ray</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> DUE TO (b) <b>C.A. of Lung with generalised metastases</b> DUE TO (c) <b>_____</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-7</b> , 19 <b>67</b> , to <b>8-24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8-24</b> , 19 <b>67</b> , and that death occurred at <b>3:30</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Rah M. Bassiri</b>		22b. DATE SIGNED <b>8.24.67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BASSIRI</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, or other final disposition (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 25 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10733

DEPARTMENT OF AGRICULTURE

FAIRBANKS

May 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

7-240722

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>BALTO</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Towson</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Essex 21221</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Balto. Medical Center</b>						d. STREET ADDRESS <b>900 Virginia Ave.</b>					
3. NAME OF DECEASED (Type or print) First <b>BABY BOY</b> Middle <b>REED</b> Last <b>REED</b>						4. DATE OF DEATH Month <b>8</b> Day <b>21</b> Year <b>19 67</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-21-67</b>		9. AGE (In years last birthday) <b>18</b>		IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. COUNTY</b>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CLAY BENNETT REED, JR.</b>						14. MOTHER'S MAIDEN NAME <b>BRUZZDZINSKI</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory anoxia</b> DUE TO <b>Meconium delivery - Prematurity</b> DUE TO <b>Asphyxia neonata</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Henry M. Beil</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BREITENBECK</b>						22d. ADDRESS <b>700 N. Charles St</b>					
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify)				23b. DATE THEREOF <b>8/24/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greater Baltimore Med. Center</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>DR. BREITENBECK</b>						ADDRESS <b>GBMC</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

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10735

CERTIFICATE OF DEATH

10736

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN b. <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7121 PARK HEIGHTS AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>Lena Reicher</u> First Middle Last		4. DATE OF DEATH <u>8 - 30 19 67</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-11-1886</u> 9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Jacob Golden</u>		14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>REICHER</u> <u>Mr. Sol Reicher</u>		Address <u>3506 NORTHRIDGE DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO <u>C.V.A. - Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>C.V.A. - Congestive Heart Failure</u> (c) <u>C.V.A. - Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs. 40 to 52 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>3</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard Cohen</u> (In Dr. Sheldon Krantz M.D.)		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Bernard Cohen</u>		22d. ADDRESS <u>3501 St. Paul Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]

4. Cause of death: [illegible]  
5. Name of physician: [illegible]

6. Name of informant: [illegible]  
7. Address of informant: [illegible]

8. Name of funeral home: [illegible]  
9. Address of funeral home: [illegible]

10. Name of cemetery: [illegible]  
11. Address of cemetery: [illegible]

12. Name of registrar: [illegible]  
13. Address of registrar: [illegible]

14. Name of registrar: [illegible]  
15. Address of registrar: [illegible]

16. Name of registrar: [illegible]  
17. Address of registrar: [illegible]

18. Name of registrar: [illegible]  
19. Address of registrar: [illegible]

20. Name of registrar: [illegible]  
21. Address of registrar: [illegible]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

10736

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10737

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex (21)</b>		c. LENGTH OF STAY IN Tb <b>03.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 Louella Ave.</b>		d. STREET ADDRESS <b>2 Louella Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>FREDRICK DOUGLAS REID</b>		4. DATE OF DEATH Month <b>August</b> Day <b>27</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 18, 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Conrad Reid</b>		14. MOTHER'S MAIDEN NAME <b>Sophia</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>705 09 2996A</b>	
17. INFORMANT <b>Frances Reid</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> DUE TO (b) <b>156.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Theo C Patterson</b>		22. DATE SIGNED <b>8/27/67</b>	
EXAMINER'S NAME (Type) <b>THEO C PATTERSON</b>		DEPUTY MEDICAL EXAMINER <b>105 Main St., Dundalk, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/30/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>James E. Bruzdziński</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>	
ADDRESS <b>1407 Eastern Ave. Balto 21</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10750

Bellevue

Box (21)

2 Louisa Ave.

W

FREDERICK DOUGLAS FIELD

XX

White

Wife

Oct. 10, 1957

Penney's

Washburn

Washburn

General Field

General

Wife

Yes

702 00 20364

General Field

Same

*Handwritten signature*

102 Main St., New York, N.Y.

W. Royal Cemetery

Washburn

Oct 10 1957

Washburn, 102 Main St., New York, N.Y.

10737

CERTIFICATE OF DEATH

10738

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, 7620 York Rd.</b>		d. STREET ADDRESS <b>320 Linwood Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>JANETT LOUISE RHOADS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1932</b>
9. AGE (In years last birthday) <b>34 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Kiskiminitas Tship, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE J. King</b>		14. MOTHER'S MAIDEN NAME <b>Mildred O. Young</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>161-26-3147</b>	
17. INFORMANT <b>Husband 838-7219</b>		Address <b>320 Linwood Avenue Bel Air, Maryland 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Cancer of Cervix</b> DUE TO (c) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>July 29, 1967</b> , to <b>August 29, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>August 29, 1967</b> , and that death occurred at <b>4:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>D. Antonio G. DeLeon</b>		22b. DATE SIGNED <b>August 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonio DeLeon, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>August 31, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Harford Co. Maryland 21014</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		25a. REC'D BY REGISTRAR <b>AUG 31 1967</b>	
ADDRESS <b>W. Broadway &amp; Williams St. Bel Air Maryland 21014</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Form with multiple sections and fields, mostly illegible due to fading. Visible text includes:

- Top header: "UNITED STATES DEPARTMENT OF AGRICULTURE"
- Section 1: "GENERAL INFORMATION"
- Section 2: "CROP INFORMATION"
- Section 3: "FARM INFORMATION"
- Section 4: "FARMER INFORMATION"
- Section 5: "FARM OPERATIONS"
- Section 6: "FARM FINANCIALS"
- Section 7: "FARM LABOR"
- Section 8: "FARM EQUIPMENT"
- Section 9: "FARM BUILDINGS"
- Section 10: "FARM UTILITIES"
- Section 11: "FARM SAFETY"
- Section 12: "FARM ENVIRONMENT"
- Section 13: "FARM COMMUNITY"
- Section 14: "FARM HISTORY"
- Section 15: "FARM FUTURE"

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF AGRICULTURAL ECONOMICS  
WASHINGTON, D. C. 20250

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Baltimore		Edgemere		Maryland		Baltimore	
c. LENGTH OF STAY IN lb		3 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM?			
BEVERLY FARM, SPARROWS R 21219				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. IS RESIDENCE ON A FARM?	
First Middle Last			Month Day Year			IF UNDER 1 YEAR IF UNDER 24 HRS.	
Raymond Eugene Rice			August 20 1967			Months Days Hours Min.	
6. SEX	7. COLOR OR RACE	8. MARRIED	9. NEVER MARRIED	10. DATE OF BIRTH	11. AGE (In years last birthday)	12. CITIZEN OF WHAT COUNTRY?	
Male	White	<input checked="" type="checkbox"/> WIDOWED	<input type="checkbox"/> NEVER MARRIED	2/5/33	34 yrs.	U. S. A.	
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13b. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country)		15. CITIZEN OF WHAT COUNTRY?	
Bricklayer		DiFerdinando & Sons		Virginia		U. S. A.	
16. FATHER'S NAME				17. MOTHER'S MAIDEN NAME			
Gilbert Rice				Marie Oats			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT (Wife)			
Yes		2		Mrs. Joyce Rice, 628 47th Dundalk, Md.			
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) DROWNED							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
22a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH				22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
<input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING				Went swimming, turned & capsized Boat			
23a. TIME OF INJURY Month, Day, Year		23b. INJURY OCCURRED		23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. LOCATION (City or town) (County) (State)	
10:00 a.m. 8-19-67		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Chic River		Harrisonburg - 19 Md.	
24. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:							
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER			
Melvin B. Davis				6800 Morn- 22. DATE SIGNED			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER			
Melvin B. Davis				ington Rd. 8/21/67			
25a. BURIAL, CREMATION, REMOVAL (Specify)				25b. DATE THEREOF		25c. NAME OF CEMETERY OR CREMATORY	
Burial				8/22/67		Mt. Clinton Church of God	
26a. FUNERAL DIRECTOR				26b. ADDRESS		26c. REC'D BY REGISTRAR	
John J. Duda, 7922 Wise Ave. Dundalk, Md.						AUG 22 1967	
27a. REGISTRAR'S SIGNATURE				27b. REGISTRAR'S SIGNATURE			
				Charles Judge			

ESQ





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10739					CERTIFICATE OF DEATH					10740				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>8 Years</b>										
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10 Winona Ave</b>					d. STREET ADDRESS <b>10 Winona Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Garnet</b>			First <b>G.</b>		Middle <b>G.</b>		Last <b>Richmond</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 18, 1896</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Harve Neely</b>					14. MOTHER'S MAIDEN NAME <b>Malinda Underwood</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>232-01-3608A</b>		17. INFORMANT (Son) Address <b>Maryland</b> <b>Karl S. Richmond, 12 Winona Ave. Dundalk.</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anterior wall Myocardial Infarction</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>6-14</b> , 19 <b>67</b> , to <b>8-7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-10</b> , 19 <b>67</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Wyman K. Wong</b>								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/8/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Wyman K. Wong</b>				22d. ADDRESS <b>M.D. 3209 Old North Point Rd. Dundalk, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Pk. Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Dorsey, Maryland</b>						
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>						25a. REC'D BY REGISTRAR <b>AUG 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						

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VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10740

CERTIFICATE OF DEATH

10741

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph's Hospital</b>				d. STREET ADDRESS <b>504 Oakland Ave. (Home)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha T. Robinson</b>				4. DATE OF DEATH Month Day Year <b>August 31 19 67</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/5/1891</b>	
9. AGE (In years last birthday) <b>74 78</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Harford Co., Maryland</b>	
13. FATHER'S NAME <b>James Allender</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Cloman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-3701D</b>		17. INFORMANT <b>Lillian B. Gonder (Daughter)</b> Address <b>3916 Woodlea Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pyelonephritis</b> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic cardiovascular disease. Diabetes mellitus.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>August 17, 19 67</b> , to <b>August 31, 19 67</b> , that (X) (we) last saw the deceased alive on <b>August 31, 19 67</b> , and that death occurred at <b>5:00 a.m.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>August 31, 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>			
22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/2/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountain Cristian Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bel Air, Md.</b>	
24. FUNERAL DIRECTOR <b>Eugenia K. Seitz 5209 York Road</b> <b>Seitz Funeral Home Balto. Md. 21212</b>				25a. REC'D BY REGISTRAR <b>SEP 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

107-9

OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

STATE OF NEW YORK		OFFICE OF THE ATTORNEY GENERAL	
IN SENATE		JANUARY 10, 1907	
REPORT		OF THE	
COMMISSIONERS OF THE LAND OFFICE		FOR THE YEAR 1906	
ALBANY:		J. B. LEECH, PRINTER.	
1907.		107-9	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10741

CERTIFICATE OF DEATH

10742

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>				MARYLAND c. LENGTH OF STAY IN lb <b>21 days</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>				d. STREET ADDRESS <b>0022</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Bartholomew</b> Last <b>Rock</b>								4. DATE OF DEATH Month <b>Aug.</b> Day <b>30</b> Year <b>1967</b>															
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-30-85</b>		9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>21</b> Hours <b>00</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY				13. FATHER'S NAME <b>William Rock</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Carey</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>022-05-7115</b>				17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of coronary artery</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 years</b> <b>15 years</b>											
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary fibrosis</b>											
												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)																			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>8-9</b> , 19 <b>67</b> to <b>8-30</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>8-30</b> 19 <b>67</b> and that death occurred at <b>5:45 PM</b> , from causes and on the date stated above.																							
22a. SIGNATURE <b>W. Newcomer</b>								M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>8-30-67</b>											
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>								22d. ADDRESS <b>Mt. Wilson, Maryland</b>															
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>9-2-1967</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Medford, Massachusetts</b>											
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>								25a. REC'D BY REGISTRAR <b>SEP 1 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

MEDICAL CERTIFICATION

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Division

Mr. Wilson

U. S. State Hospital

U. S. State Hospital

U. S. State Hospital

U. S. State Hospital

U. S. State Hospital

U. S. State Hospital

U. S. State Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10742					10743				
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				
c. LENGTH OF STAY IN 1b 36 days					d. STREET ADDRESS 3721 Marmon Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Anna Julia Roeder			4. DATE OF DEATH Month Day Year 8 8 1967						
5. SEX Female		6. CILDR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/76		9. AGE (In years last birthday) 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Wiesner				14. MOTHER'S MAIDEN NAME Lessner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. ----		17. INFORMANT Regina R. Hornung-3721 Marmon Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 7/3/1967, to 8/8, 1967, that (I) (we) last saw the deceased alive on 8/8/1967, and that death occurred at 7:30 P.M., from the causes and on the date stated above.									
22a. SIGNATURE John E. Adams								22b. DATE SIGNED 8/9/67	
22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D.								22d. ADDRESS 6701 N. Charles Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-11-67		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts. Ave.						25a. REC'D BY REGISTRAR AUG 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10743

Item #2d Film #4392 9/5/67 ph

## CERTIFICATE OF DEATH

10744

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MILFORD MANOR NURSING HOME</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>304</u> d. STREET ADDRESS <u>7121 Park Hgts. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>HATTIE ROSEN BUSH</u>		<b>4. DATE OF DEATH</b> <u>AUG 27 1967</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/28/1873</u>		<b>9. AGE</b> (In years last birthday) <u>93</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>  </u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>WASH. D.C.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>13. FATHER'S NAME</b> <u>SAMUEL</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>JOHANNA</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>						<b>16. SOCIAL SECURITY NO.</b> <u>  </u>						<b>17. INFORMANT</b> <u>MRS. EDITH R. BLUM</u> Address <u>7121 PARK HEIGHTS</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO <u>  </u> (c)														INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>				<b>20f. (City or town)</b> (County) (State) <u>  </u>					
<b>21. I certify</b> that (I) (the hospital) attended the deceased from <u>July 1, 1955</u> to <u>Aug 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 27, 1967</u> , and that death occurred at <u>3:25</u> M, from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <u>Sumner Collier</u> M.D.										<b>22b. DATE SIGNED</b> <u>8/28/67</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Sumner Collier M.D.</u>										<b>22d. ADDRESS</b> <u>2217 South Rd</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8/28/67</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Balto Hebrew</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Balto Md</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Sydney S. Lewis &amp; Son, INC Garrison, Md</u>																	
<b>25a. REC'D BY REGISTRAR</b> <u>AUG 29 1967</u>								<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. J. Jones</u>									

10785

UNITED STATES OF AMERICA

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Continental C.V.D.

July 10, 1934

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*[Handwritten signature]*

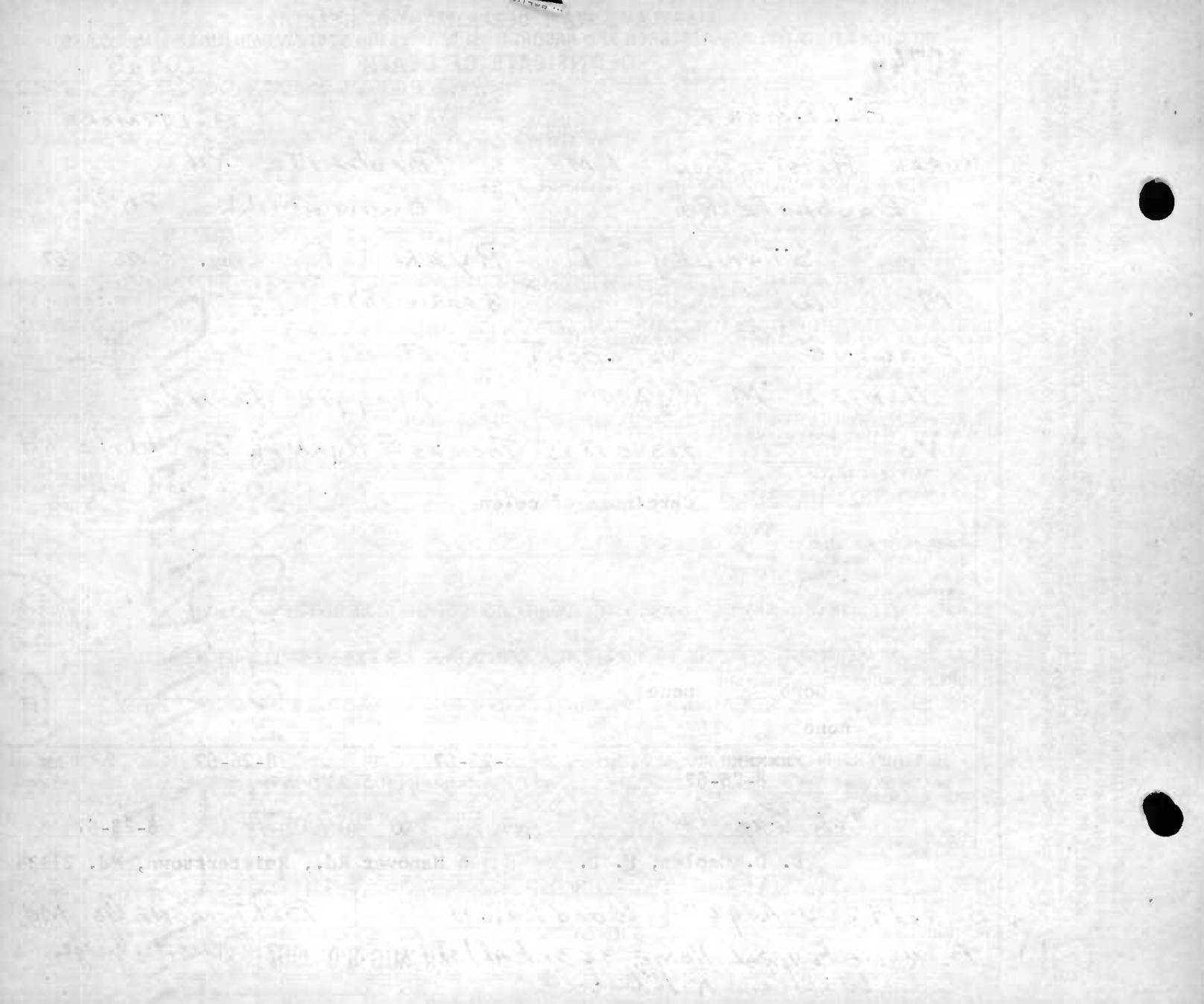
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10744					CERTIFICATE OF DEATH					10745				
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL REISTERSTOWN</b> c. LENGTH OF STAY IN 1b <b>1 Mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>BAUBLITZ RD.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BAUBLITZ RD</b> d. STREET ADDRESS <b>OWINGS MILLS. P.O.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>STANLEY D RYAN</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>26</b> Year <b>1967</b>											
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 APRIL 1899</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FORGING</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>NOT A BOAT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>DANIEL M. RYAN</b>					14. MOTHER'S MAIDEN NAME <b>MAGGIE BOND</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>213 10 1835</b>		17. INFORMANT <b>THOMAS E. RYAN</b>		Address <b>BAUBLITZ RD</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>none</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <b>8-25-67</b> , 19__, to <b>8-26-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>8-25-67</b> , 19__, and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>D. D. Caples</b>					22b. DATE SIGNED <b>8-28-67</b>									
22c. PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>					22d. ADDRESS <b>6 Hanover Rd., Reisterstown, Md. 21136</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>29 AUG 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE Co. Md.</b>								
24. FUNERAL DIRECTOR ADDRESS <b>BURGEE FUNERAL HOME 3631 FALLS RD</b> <b>William R Kleiber</b>					25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>							

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10746

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>849 Loalan Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM J. RYTINA</b>		4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1935</b>
9. AGE (In years last birthday) <b>32 Yrs.</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Display man</b>		12. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>James F. RYTINA</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>213-32-8159</b>	
17. INFORMANT <b>James F. Rytina</b>		Address <b>849 Loalan Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Combination overdose of Doriden,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Barbiturate and alcohol</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subject committed suicide</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. ? ? 19 p.m. ? ?	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ?	20f. (City or town) (County) (State) ? ? ?
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		22. DATE SIGNED <b>August 28, 1967</b>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		23. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-1-67</b>	23c. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Philip E. Crach</b>		25. REC'D BY REGISTRAR <b>SEP 5 1967</b>	
ADDRESS <b>1211 Chestco Ave.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8823 Liberty Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> d. STREET ADDRESS <b>8823 Liberty Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Mamie</b>			First		Middle		Last		4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1967</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 9, 1892</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Lassner</b>					14. MOTHER'S MAIDEN NAME <b>Minnia Gebhart</b>					Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-07-3698</b>		17. INFORMANT <b>Miss Bessie E. Holtman 8823 Liberty Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lymphosarcoma of bone.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <b>2/2</b> , 1966 to <b>6/26</b> , 1967, that (II) (we) last saw the deceased alive on <b>6/26/66</b> , and that death occurred at <b>2/2</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>John Darrell</b>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/15/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. John J. Darrell</b>					22d. ADDRESS <b>9017 Liberty Road Randallstown, Md</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>			23d. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>					ADDRESS <b>8728 Liberty Road Randallstown Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

10746

Baltimore

Manassas

8833 Liberty Road

Male

Female

Domestic

John L. Smith

510-0-King James Street, N. W., Washington, D. C.

no

Dr. John V. Smith

8/10/57

Baltimore

Baltimore

Maryland

Liberty Road, Manassas, Va. 22040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10747

10748

1. PLACE OF DEATH a. COUNTY <u>Balto Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		d. STREET ADDRESS <u>Jerusalem Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>at his home Jerusalem Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thurman Carroll Sanders</u>		4. DATE OF DEATH Month Day Year <u>Aug 4 1967</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 2, 1892</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Martin</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pancast Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Geo. W. Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Dyke</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>413-03 6843</u>		17. INFORMANT <u>Amjette M Replunge</u>		Address <u>Kingsville Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mesenteric Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Insufficiency</u> (c) <u>Arteriosclerosis</u> DUE TO (e), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic Bronchitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>Aug 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> , 19 <u>67</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE <u>William H. Tyson</u> M.D.		22c. PHYSICIAN'S NAME (Type) <u>William H. Tyson</u>		22d. ADDRESS <u>Kingsville Md</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		23d. LOCATION (City, town or county) (State) <u>Overlea Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10781

10-1-1981  
10-1-1981  
10-1-1981

10-1-1981  
10-1-1981  
10-1-1981



## CERTIFICATE OF DEATH

10749

10749

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Joseph's Hospital</b>		c. LENGTH OF STAY IN 1b <b>Towson</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>121 Greenbrier Rd. #21204</b>	
3. NAME OF DECEASED (Type or print) <b>Dewey C. Santa</b>		First Middle Last		4. DATE OF DEATH <b>August 29 1967</b>		Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 5, 1914</b>		9. AGE (In years last birthday) <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grinnell Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Angelio Santa</b>				14. MOTHER'S MAIDEN NAME <b>Sue Varrato</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-3766</b>		17. INFORMANT <b>Family records</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured dissecting aneurysm</b> DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>451X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>August 17, 1967</b> , to <b>August 29, 1967</b> , that <del>at</del> (we) last saw the deceased alive on <b>August 29, 1967</b> , and that death occurred at <b>12:40 AM</b> from causes and on the date stated above.									
22a. SIGNATURE <i>Lawrence F. Misanik</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>August 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M.D.</b>				22d. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 31, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Maryland</b>			
24. FUNERAL DIRECTOR <b>John B. Burns &amp; Sons</b>				ADDRESS <b>610-612 York</b>		25a. REC'D BY REGISTRAR <b>SEP 5 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10240

UNITED STATES OF AMERICA

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

AT ITS SESSION

ON JANUARY 1, 1900

AND

AT THE

ANNUAL MEETING

OF THE

COMMISSIONERS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10748

CERTIFICATE OF DEATH

10750

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		MARYLAND c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1706 Weston Ave. #21234</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>1706 Weston Ave. #21234</b>	
3. NAME OF DECEASED (Type or print) <b>Francis J. Scally</b>		First <b>J.</b>		Middle <b>Scally</b>	
4. DATE OF DEATH Month <b>August</b>		Day <b>11</b>		Year <b>19 67</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>August 3, 1916</b>		9. AGE (In years lost birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of two years immediately preceding death) <b>Sub Sta. Oper Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Gas &amp; Elec.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Francis J. Scally</b>		14. MOTHER'S MAIDEN NAME <b>Eileen T. Flynn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214 03 1700</b>		17. INFORMANT <b>Margaret Scally</b> Address <b>1706 Weston Av. Balto Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Pulmonary edema</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>August 10, 1967</b> , to <b>August 11, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 11, 1967</b> , and that death occurred at <b>6:00AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>Jaime Singzon</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 11, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jaime Singzon, M.D.</b>		22d. ADDRESS <b>7620 York Road #21204</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Balto. Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. E. Johnson. 8521 Loch Raven Blvd. Balto.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>AUG 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>					

1997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10750

10751

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Balto. Co. General Hospital</b>				d. STREET ADDRESS <b>2701 Rolling Road Balto 7, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MORGAN, L. Schisler</b>				4. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>1967</b>			
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/23/00</b>	9. AGE (In years last birthday) yrs. <b>66</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Bldg.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Schisler</b>				14. MOTHER'S MAIDEN NAME <b>Daisy M. Bush</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-12-8369</b>		17. INFORMANT <b>Mrs. Eunice Schisler 2701 Rolling Rd. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion Sudden</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)				19. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		EXAMINER'S NAME (Type) <b>Charles. F. O'Donnell, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>8/6/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Balto Co Md.</b>	
24. FUNERAL DIRECTOR <b>Loring Myers 8728 Liberty Rd Randallstown Md</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>AUG 10 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10770

Belmont

Belmont

Belmont Co. General Hospital

Belmont Co. General Hospital

Belmont

Belmont

W

12/23/00

Belmont

Belmont

Belmont

Belmont

John H. Belmont

John H. Belmont

no

no

no

Belmont

Belmont

Belmont

Belmont

Belmont

12/23/00



5-1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10751

CERTIFICATE OF DEATH

10752

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pr. Geo.</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>16-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		d. STREET ADDRESS <b>5111 Alton Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie</b>		4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-28-13-94</b> 9. AGE (In years lost birthday) yrs. <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rafferty</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-66-0380</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Urinary Infection.-Several decubital ulcers(back,sacram,hips,elbows)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." "p.m." <b>none</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-5</b> , 19 <b>66</b> , to <b>8-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>August 5</b> , 19 <b>67</b> , and that death occurred at <b>7:15P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Imre Kopits</b>		22b. DATE SIGNED <b>8/5/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Imre KOPITS, M.D. (K-7077)</b>		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Parkville, Balto. Co., Md</b>	
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10037

Canonville

Spring Grove State Hospital

White

Female White

Nonpareil

John Hattery

77-66-030

Brookhaven

Arteriosclerotic Heart Disease

Generalized Arteriosclerosis

Primary infection - lateral decubital abscess, necrotic, abscess

None

None

August 2, 1957

*Thomas*

Irma Korb, M.D. (1-171)

Spring Grove State Hospital  
Hartford, Maryland 21538

Spring Grove State Hospital

John H. Hattery, M.D. 1905, M.D. 1907

February 15, 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b> c. LENGTH OF STAY IN 1b <b>years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>905 Breezewick Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson 21204</b> d. STREET ADDRESS <b>905 Breezewick Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>WYATT</b> Middle <b>SCHOONMAKER</b> Last <b>SCHOONMAKER</b>					4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 16, 1901</b>		9. AGE (In years last birthday) <b>66 yrs.</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Titanium Pigment Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan Wyatt Schoonmaker</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Skinner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>084-01-7877</b>		17. INFORMANT Address <b>Mrs. Ruth Schoonmaker, Same as # 2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Disease</b> <b>260X</b> DUE TO (b) <b>Hypertensive a. S. C. V. D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Diabetes mellitus</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks +</b> <b>Several yrs</b> <b>11</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Asthmatic Bronchitis</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19 <b>63</b> , to <b>Aug 26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Aug 25</b> , 19 <b>67</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Samuel Morrison</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/26/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL MORRISON</b>					22d. ADDRESS <b>11 E. Chase St. 21202</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>Aug. 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cockeysville, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Rd. Towson, Md</b>					25. REC'D BY REGISTRAR <b>AUG 29 1967</b>				
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

M

10753

10754

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> <u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1413 Sulphur Spring Rd.</u>		d. STREET ADDRESS <u>1413 Sulphur Spring Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ida Schrage</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/07</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Business Mach.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Schrage</u>		14. MOTHER'S MAIDEN NAME <u>Marie Schneider</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-5732</u>	
17. INFORMANT <u>Anna Morgan</u>		Address <u>1413 Sulphur Sp. Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1810</u> IMMEDIATE CAUSE (a) <u>Respiratory and cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis secondary to carcinoma of urinary bladder</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>do not know</del> ) attended the deceased from <u>Nov. 16, 1966</u> to <u>Aug. 26, 1967</u> , that (I) ( <del>we</del> ) saw the deceased alive on <u>July 29, 1967</u> , and that death occurred at <u>1 a.m.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>S. J. Liu</u>		22b. DATE SIGNED <u>Aug. 26, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. Liu, M. D.</u>		22d. ADDRESS <u>5301 Harford Rd. Balto., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Embrose Inc. 1328 Sulphur Sp. Rd.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





10754

10755

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>House In The Pines</b>		d. STREET ADDRESS <b>4300 Wilkens Ave. 21229</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frieda</b> Middle <b>A.</b> Last <b>Schwanebeck</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/93</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Schwanebeck</b>		14. MOTHER'S MAIDEN NAME <b>Martha Kietzler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-0746</b>	
17. INFORMANT <b>Mr. Harry F. Schwanebeck, 4300 Wilkens Ave.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C. V. Disease</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>10 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>57</b> , to <b>Aug 10</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Aug 4</b> , 19 <b>67</b> , and that death occurred at <b>4</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John F. Coolahan</b>		22b. DATE SIGNED <b>8/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Coolahan</b>		22d. ADDRESS <b>4201 Wilkens Ave.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kx Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Hyphantornis

James



John F. Crotcher

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10755

10756

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> c. LENGTH OF STAY IN 1b <b>25 Years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b> d. STREET ADDRESS <b>6702 Old North Point Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>Stewart</b> Last <b>Scott</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1906</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>0</b> Min. <b>03-1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co. Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Scott</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Jane Scott</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-7654</b>	
17. INFORMANT (Daughter) <b>Arlene Scott, 6702 Old North Point Rd.</b>		18. INFORMANT (Daughter) <b>Edgemere, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>A-S-P-C-V-Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Morn- 22. DATE SIGNED</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/17/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Unionville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Unionville, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		25c. REGISTRAR'S SIGNATURE	

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mount Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3011</b> d. STREET ADDRESS <b>2621 W. Cold Spring Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raleigh</b> Middle <b>Scott</b> Last <b>Scott</b> 4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1967</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11-5-29</b> 9. AGE (In years) last birthday <b>37</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>S. Carolina</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>William Scott</b> 14. MOTHER'S MAIDEN NAME <b>Jannie Woods</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>246-42-668</b> 17. INFORMANT <b>Records, Mount Wilson State Hospital</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonalis</b> 5072 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic obstructive airway disease</b> DUE TO (c) <b>2 yrs</b> INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>0021 Pulmonary Tuberculosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>8-2</b> , 19 <b>67</b> , to <b>8-18</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>8-18</b> , 19 <b>67</b> , and that death occurred at <b>12:58 PM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>W. Newcomer</b> 22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland</b> 22d. ADDRESS <b>1121 North</b> 22b. DATE SIGNED <b>AUG 23 1967</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>8/22/67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b> 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Phillips Funeral Home</b> 25a. REC'D BY REGISTRAR <b>AUG 23 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10750

RECORD OF DEATH

DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

CAUSE OF DEATH

DIAGNOSIS

TREATMENT

PROGNOSIS

REMARKS

SIGNATURE

DATE

TIME

PLACE

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OF

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# FOR STATE HEALTH DEPT.

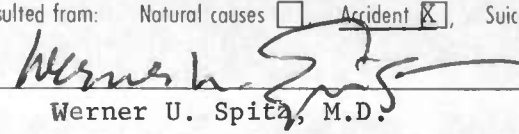
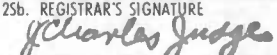
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

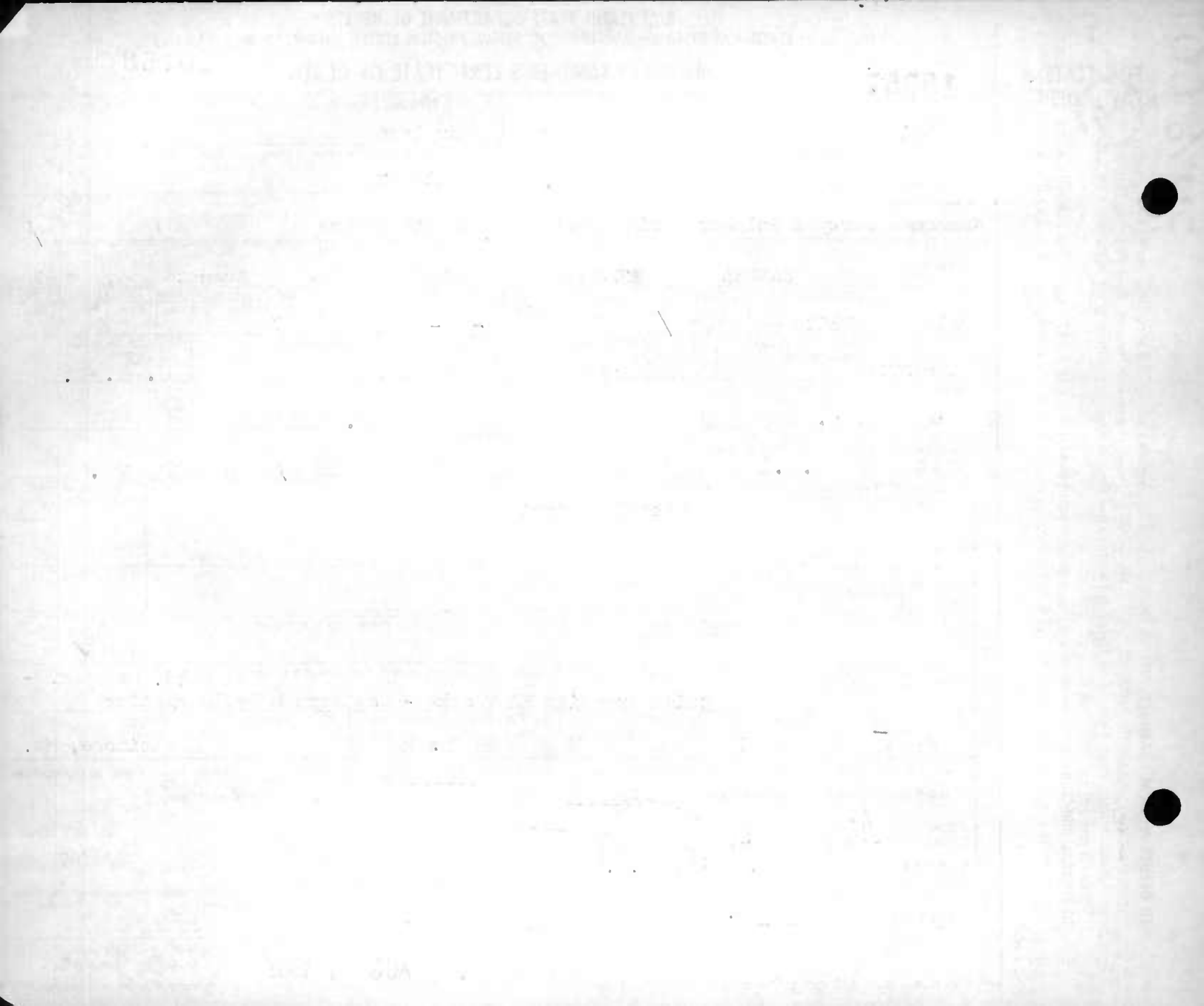
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN lb <b>37 yrs.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hammonds Ferry &amp; Sulphur Spring Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SAMUEL TELGHMAN SEYMOUR</b>			4. DATE OF DEATH Month Day Year <b>August 4, 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-1896</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Account</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			13. FATHER'S NAME <b>Samuel J. Seymour</b>		
14. MOTHER'S MAIDEN NAME <b>Mary R. Twilley</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes W.W.1</b>		
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Sophroina Seymoure 340 5th Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Subj. was pedestrian crossing RR Tracks - was struck by locomotive</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>6:30 p.m.</b> <b>8 4 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RR Tracks</b>	
		20f. (City or town) (County) (State) <b>Baltimore, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. <b>Werner U. Spitz, M.D.</b>		22. DATE SIGNED <b>8/4/67</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-8-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>	
24. FUNERAL DIRECTOR <b>Ambrose Funeral Home 1328 Sulphur ss.</b>		25a. REC'D BY REGISTRAR <b>AUG 7 1967</b>		25b. REGISTRAR'S SIGNATURE 	
23d. LOCATION (City or Town) (County) (State) <b>Dorsey Maryland</b>					

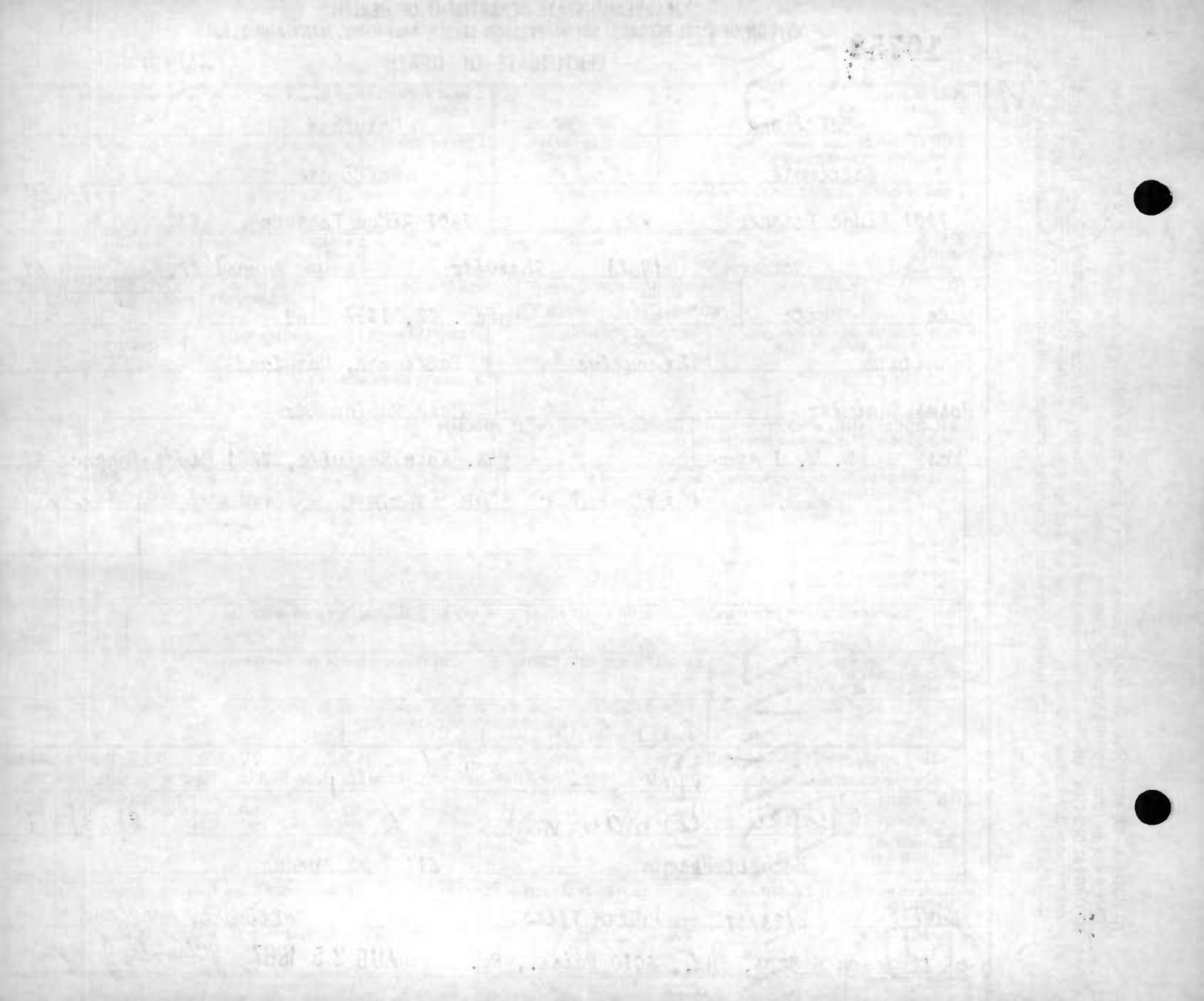


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
10758		CERTIFICATE OF DEATH		10759		
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7801 Ridge Terrace #8</u>			d. STREET ADDRESS <u>7801 Ridge Terrace #8</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Solomon (Sol) Shaivitz</u>			4. DATE OF DEATH <u>August 22, 1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 22, 1898</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Executive</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		
13. FATHER'S NAME <u>Moses Shaivitz</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W. W. I Army</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Rose Shaivitz, 7801 Ridge Terrace #8</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - Signed</u> 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/29, 1967</u> , to <u>8/22, 1967</u> , that (I) (we) last saw the deceased alive on <u>8/16, 1967</u> , and that death occurred at <u>7 p.m.</u> from causes and on the date stated above.						
22a. SIGNATURE <u>Barnett Berman, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/23/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Barnett Berman</u>		22d. ADDRESS <u>611 Park Avenue</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>			25a. REC'D BY REGISTRAR DATE <u>AUG 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10753		10760	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u> Md </u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>734 Warwick Road</u>		d. STREET ADDRESS <u>734 Warwick Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edward P. Shanahan</u> First Middle Last		4. DATE OF DEATH <u>August 19 1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 5, 1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trust Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1st National Bank</u>	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward P. Shanahan</u>		14. MOTHER'S MAIDEN NAME <u>Theresa McQuirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Lourdean M. Shanahan, 734 Warwick Rd.</u>		Address <u>21229</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung - Heart Failure</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bleeding ulcer</u> (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of Lung</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 63</u> , to <u>Aug 19 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard M. Susel</u>		22b. DATE SIGNED <u>August 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard M. SUSSEL</u>		22d. ADDRESS <u>4001 Wilkens Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>8-22-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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10760

## CERTIFICATE OF DEATH

10761

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowson</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pickersgill</u>		d. STREET ADDRESS <u>3108 Walbrook Ave</u> 30.4	
3. NAME OF DECEASED (Type or print) <u>Edith Shooly</u> First Middle Last		4. DATE OF DEATH <u>August 19 1967</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4, 1881</u> 86 yrs.
9. AGE (In years last birthday) <u>86</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u> Hours <u>—</u> Min. <u>—</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cannvasser</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>James C Shooly</u>		15. MOTHER'S MAIDEN NAME <u>Mary Frederick</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>215-54-1671</u>	
18. INFORMANT <u>A. Marie Weaver R.N.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 19 1967</u> , 19 <u>53</u> to <u>August 19 1967</u> , that (I) (we) last saw the deceased alive on <u>August 19 1967</u> , and that death occurred at <u>6:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edward Day</u> M.D.		22b. DATE SIGNED <u>August 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day MD</u>		22d. ADDRESS <u>4-E-33rd St Balto. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 22 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>
24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1050 Gough Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 24 1967</u>			

10780

STATE OF TEXAS

County of ...  
State of Texas  
I, the undersigned, Clerk of the County of ...  
do hereby certify that ...  
Witness my hand and seal of office this ... day of ...  
A.D. 19...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b></p> </div> <div> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>10762</p> </div> </div>										
<p>1. PLACE OF DEATH a. CDUNTY <b>Baltimore</b> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b></p>					
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p>			<p>c. LENGTH OF STAY IN 1b</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rodgers Forge, Balto. Co.</b></p>			<p>d. STREET ADDRESS <b>7028 Heathfield Rd-12</b></p>		
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7028 Heathfield Road</b></p>					<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) First <b>ANITA M.</b> Middle <b>SHEESLEY</b> Last</p>		<p>4. DATE OF DEATH Month <b>August</b> Day <b>28th</b> Year <b>1967</b></p>		<p>5. SEX <b>Female</b></p>		<p>6. COLOR OR RACE <b>White</b></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		
<p>8. DATE OF BIRTH <b>Jan. 14, 1868</b></p>		<p>9. AGE (In years last birthday) <b>99</b> yrs.</p>		<p>10. IF UNDER 1 YEAR Months Days</p>		<p>11. IF UNDER 24 HRS. Hours Min.</p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>		
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b></p>					<p>10b. KIND OF BUSINESS OR INDUSTRY -----</p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Baltimore, Md.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>DANIEL SHEESLEY</b></p>					<p>14. MOTHER'S MAIDEN NAME <b>MARY TWOMEY</b></p>					
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no-</b></p>		<p>16. SOCIAL SECURITY NO. <b>--</b></p>		<p>17. INFORMANT <b>Mrs. Virginia Hartis-</b></p>		<p>Address <b>Same</b></p>				
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe myocardial changes</b> 48 yrs. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>									<p>INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b></p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>										
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>			<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>			<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 27, 1967</b>, to <b>Aug. 27, 1967</b>, that (I) (we) last saw the deceased alive on <b>Aug. 27, 1967</b>, and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.</p>										
<p>22a. SIGNATURE <b>J. Willis Guyton</b></p>					<p>22b. DATE SIGNED <b>8/29/67</b></p>		<p>22c. PHYSICIAN'S NAME (Type) <b>J. Willis Guyton M.D.</b></p>			
<p>22d. ADDRESS <b>3961 Greenmount Ave.</b></p>										
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>			<p>23b. DATE THEREOF <b>8/31/67</b></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b></p>		<p>23d. LOCATION (City, town or county) (State) <b>Balto.</b></p>			
<p>24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home-6500 York Rd. 21212</b></p>					<p>25a. REC'D BY REGISTRAR <b>SEP 1 1967</b></p>		<p>25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b></p>			

13001

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

100-100000-100

STANDARD FORM NO. 64

OFFICE OF THE SECRETARY OF DEFENSE

WASHINGTON, D.C. 20301

100-100000-100



STANDARD FORM NO. 64

100-100000-100

OFFICE OF THE SECRETARY OF DEFENSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
10762		CERTIFICATE OF DEATH		10763	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MD</u> <u>21204</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>6206 N. Chesapeake</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>Enter</u> <u>Mary VICK Shenton</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/04</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jonesborough, N.C.</u>	
13. FATHER'S NAME <u>XXXXXXXX Alexander Vick</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXXXX Stella Currie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-22-2429</u>		17. INFORMANT <u>Mr. Richard C. Shenton</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/6/67</u> , 19 <u>  </u> , to <u>8/6, 1967</u> , that (I) (we) last saw the deceased alive on <u>8/6/1967</u> , and that death occurred at <u>6:25 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Nasser Eftekhari</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Nasser Eftekhari</u>		22d. ADDRESS <u>GBMG</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
23d. LOCATION (City or Town) <u>Woodlawn, Md.</u>		(County)		(State)	
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc. 6500 York Rd.</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>AUG 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Judge</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10763

CERTIFICATE OF DEATH

10764

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City 21223</b>		d. STREET ADDRESS <b>342 S. Bentalou St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Augusta E. Shipley</b>		4. DATE OF DEATH Month Day Year <b>8 26 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1906</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>26 19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Christopher Lang</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Dorch</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>219-30-5587</b>	
17. INFORMANT <b>Records: Spring Grove State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shock</b> DUE TO (c) <b>possible myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>36 hrs</b> <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1967</b> , to <b>July 19, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7/20 1967</b> , and that death occurred at <b>4:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Am-Louise Silver</b>		22b. DATE SIGNED <b>8/26/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Spring Grove State Hospital Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>8-29-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SMITH FAMILY</b>	23d. LOCATION (City or Town) (County) (State) <b>SEVERN A.A. Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Miller 2101 Frederick Ave</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 29 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1907

MINISTRE DU COMMERCE

Le Directeur

Caracas

Parque, 1000, 1000, 1000

Caracas

Caracas

Caracas

Caracas

Caracas

Caracas

Caracas

X

X

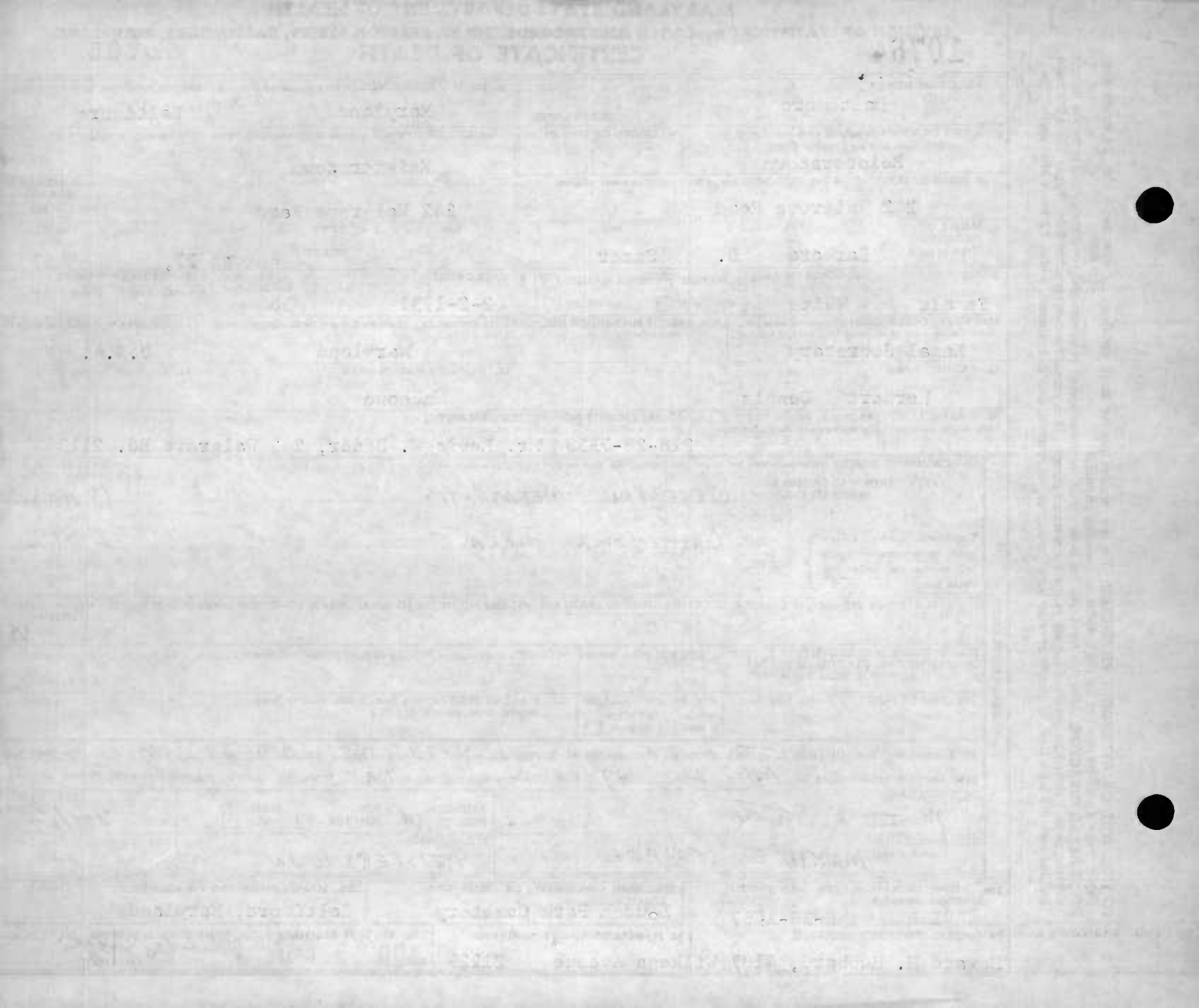
Caracas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 5-63

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
10764													
10765													
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>242 Walgrove Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> d. STREET ADDRESS <b>242 Walgrove Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Barbara D. Sizer</b>						4. DATE OF DEATH <b>August 27, 1967</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-2-1931</b>		9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Legal Secretary</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Herbert Dennis</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>218-28-7333</b>		17. INFORMANT <b>Mr. Lewis W. Sizer, 242 Walgrove Rd. 21136</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL METASTASIS</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>CARCINOMA BREAST</b> a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>18 HRS.</b> <b>2 YRS.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 23, 1967</b> , to <b>AUG. 27, 1967</b> , that (I) (we) last saw the deceased alive on <b>AUG. 26, 1967</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Martin E. Strubel</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/27/67</b>					
22c. PHYSICIAN'S NAME (Type) <b>MARTIN E. STRUBEL</b>						22d. ADDRESS <b>REISTERSTOWN, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-30-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>						25a. REC'D BY REGISTRAR <b>AUG 29 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

10765

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10766

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State</u>				d. STREET ADDRESS <u>Obrecht Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> First <u>ARRINGTON</u> Middle <u>SMITH</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-95</u>	9. AGE (In years lost birthday) <u>72 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WOODSBORO, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip Smith</u>				14. MOTHER'S MAIDEN NAME <u>SARAH Arrington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-36-4608</u>		17. INFORMANT <u>Mrs B. Mans</u> Address <u>53, Springfield Ave., Sykesville 21764</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X Asthmatic Bronchitis</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 28, 1967</u> , to <u>Aug. 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 12, 1967</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert E. Ludicke</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert E. Ludicke</u>				22d. ADDRESS <u>Spring Grove Hospital - Catonsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City or Town)		(County)	(State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Naight</u>				ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

10762

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

State of ...

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10766

CERTIFICATE OF DEATH

10767

1. PLACE OF DEATH a. COUNTY <u>DALTON CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>DALTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
5431 CHANNING RD.		5431 CHANNING RD.	
3. NAME OF DECEASED (Type or print) <u>ORVILLE A. SMITH</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACH.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL CO.</u>	
13. FATHER'S NAME <u>PETER SMITH</u>		14. MOTHER'S MAIDEN NAME <u>ANNA REUSING</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-5330</u>	
17. INFORMANT <u>ANN V. SMITH</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> DUE TO (b) <u>1538</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 1, 1967</u> , to <u>August 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1967</u> , and that death occurred at <u>SA, M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morris Steinberg</u>		22b. DATE SIGNED <u>8/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MORRIS STEINBERG</u>		22d. ADDRESS <u>3113 HOLLINS FERRY RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>E. S. MALNAB</u>		25a. REC'D BY REGISTRAR <u>21228</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 7 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove original papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

67

10767

## CERTIFICATE OF DEATH

10768

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8131 Loch Raven Blvd.</b>						d. STREET ADDRESS <b>8131 Loch Raven Blvd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT THOMAS SMITH</b>						4. DATE OF DEATH <b>August 5th, 1967</b>		Month <b>August</b>		Day <b>5th</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 31, 1913</b>		9. AGE (In years lost birthday) <b>54 yrs.</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Balto City</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. Lewis Smith</b>						14. MOTHER'S MAIDEN NAME <b>Maude Parrish</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>299-01-3123</b>		17. INFORMANT <b>Mrs. Marie N. Smith</b>				Address <b>same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion Sudden</b> <b>4201</b> DUE TO (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>3yr</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 4, 1958</b> to <b>Aug 5, 1967</b> , that (I) (we) last saw the deceased alive on <b>8/5/67</b> , and that death occurred at <b>9:20</b> M, from causes and on the date stated above.											
22a. SIGNATURE <b>Charles F. O'Donnell</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/8/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/8/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Park</b>				23d. LOCATION (City or Town) (County) (State) <b>Balto Co.</b>	
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home, Inc.</b>						25a. REC'D BY REGISTRAR <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
6500 York Road, 21212											

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ENGINE AIR OF DAY

1976

DATE: 10/1/76

TIME: 10:00 AM

LOCATION: 100-10-10

DESCRIPTION: 100-10-10

REMARKS: 100-10-10

100-10-10

100-10-10

100-10-10

100-10-10

100-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10768

CERTIFICATE OF DEATH

10769

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY in 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>190 clay Str.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDWARD</b> First <b>SORRELL</b> Last				4. DATE OF DEATH Month <b>8</b> Day <b>21</b> Year <b>67</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.18.1905</b>		9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator operator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LOUIS SORRELL</b>				14. MOTHER'S MAIDEN NAME <b>JOSEPHINE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>204-05-1554</b>		17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of sigmoid colon. Emphysema</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7.31.</b> , 19 <b>67</b> , to <b>8.21.</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8.21.</b> 19 <b>67</b> , and that death occurred at <b>2:40 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Wm. Newcomer</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8.21.1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>				22d. ADDRESS <b>Mt. Wilson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-24-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Charles R. Law 802 Madison Ave., Balto., Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>	

1078

RECEIVED BY MAIL

Bellevue  
St. Louis

St. Louis, Mo. 63101

Mr. Wm. W. W. W.

St. Louis, Mo.

St. Louis, Mo.

St. Louis, Mo. 63101

St. Louis, Mo.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10769					10770				
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b <u>73 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				30.1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>					d. STREET ADDRESS <u>7427 Hartford Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>May Mary Spuck</u>			4. DATE OF DEATH Month Day Year <u>8 19 1967</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-93</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jerry (unknown)</u>					14. MOTHER'S MAIDEN NAME <u>Jane</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>213-34-637D</u>		17. INFORMANT <u>Jim</u>		Address <u>Jane</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sever anemia</u> DUE TO (c) <u>terminal ca of breast with metastas to brain</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>67</u> , and that death occurred at <u>5:15 P</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>P. nandi</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>8-19-67</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, or REMOVAL (Specify)			23b. DATE THEREOF <u>Aug 22 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountland</u>		23d. LOCATION (city, town or county) (State) <u>Bald</u>		
24. FUNERAL DIRECTOR <u>Pl Steedman</u>					ADDRESS <u>6067 Hay Rd</u>		25a. REC'D BY REGISTRAR <u>AUG 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

perennial or short-lived plants  
evergreen

various - unknown

*[Handwritten notes at bottom of page:]*

76-81-8 ✓      76-81-8 30  
76-81-8 30      76-81-8 30  
76-81-8 30      76-81-8 30

Throat and Chest

10770

## CERTIFICATE OF DEATH

10771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>				d. STREET ADDRESS <u>3501 Olympia Avenue #15</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>Stain</u>				4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>XXXXXXXXXXXX</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mr. Harry Krongard, 3501 Olympia Avenue</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death Syndrome, probable CVA</u> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>@ optic neuritis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Not Known</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>67</u> , to <u>8-12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8-12</u> , 19 <u>67</u> , and that death occurred at <u>7:25a</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Diadema B. Simon, MD</u>				22b. DATE SIGNED <u>8-12-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Diadema B. Simon</u>	
22d. ADDRESS <u>Baltimore County General Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

# REPORT OF DEATH

10710

DECEASED

1. Name

2. Sex

3. Date of Birth

4. Place of Birth

5. Race

6. Religion

7. Education

8. Occupation

9. Marital Status

10. Cause of Death

11. Date of Death

12. Place of Death

13. Signature of Physician

14. Signature of Registrar

15. Signature of Coroner

8-10

8-15

Diabetes & heart ma

8-15-41

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME-15  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10771

12176

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>483</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Miami Beach</b> d. STREET ADDRESS <b>Miami Beach, Florida</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALFRED STERN</b> First Middle Last 4. DATE OF DEATH <b>August 22 19 67</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>53</b> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) yrs. <b>53</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>4221</b> 11. BIRTHPLACE (State or foreign country) <b>Arteriosclerotic Cardiovascular Disease</b> 12. CITIZEN OF WHAT COUNTRY? <b>Arteriosclerotic Cardiovascular Disease</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (b) <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerotic Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>August 23, 1967</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>9-11-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>10. 9. med. Med. School</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>SEP 13 1967</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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THE UNIVERSITY OF CHICAGO

THE UNIVERSITY OF CHICAGO  
IN THE DEPARTMENT OF CHEMISTRY  
1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

10772

Item #2d Film #0392 9/15/67

10772

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOUSON</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		d. STREET ADDRESS <u>1815 Harford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>(NAN)</u> Last <u>STIRZEL</u>		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.A.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adolph E. Frick</u>		14. MOTHER'S MAIDEN NAME <u>Anna Gusner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-24-2103</u>	
17. INFORMANT Address <u>PT'S. HOSPITAL CHART</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA metast.</u> DUE TO (b) <u>Adenocarcinoma of the stomach with metast.</u> stating the underlying cause last. (c) <u>to colon - Subphrenic abscess</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> , 19 <u>67</u> , to <u>8/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Monday 8/22/1967</u> , and that death occurred at <u>11:22 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Nasser Eftekhari</u>		22b. DATE SIGNED <u>8/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>NASSER EFTEKHARI M.D.</u>		22d. ADDRESS <u>6701 N. Charles St Balto MD. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Md. 21212</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Phyllis Judge</u>

EXHIBIT A

EXHIBIT B

CO. 100

Admission of the stomach with metastasis to colon - 2nd pharynx cancer

Exhibit A

Exhibit B

Exhibit C

Exhibit D

Exhibit E

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>57 years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		d. STREET ADDRESS <b>103 Westminster Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>103 Westminster Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leola</b> Middle <b>May</b> Last <b>Stolpp</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Worrell</b>		14. MOTHER'S MAIDEN NAME <b>Ida May Wink</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-4885</b>	
17. INFORMANT <b>Mrs. Phyllis Fox</b>		Address <b>Walnut Avenue, Owings Mills, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>L. V. &amp; R. D. hypertension</b> DUE TO <b>Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>few days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-7-</b> , <b>1967</b> to <b>8-22-</b> , <b>1967</b> , that (I) <b>was</b> last saw the deceased alive on <b>8-21-</b> , <b>1967</b> , and that death occurred at <b>10A</b> AM, from causes on and on the date stated above.			
22a. SIGNATURE <b>James G. Saffell M.D.</b>		22b. DATE SIGNED <b>8-22-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Reisterstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 24, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pikesville, Maryland.</b>	
24. FUNERAL DIRECTOR <b>H. J. Schhardt</b>		ADDRESS <b>Owings Mills, Md.</b>	
25a. REC'D BY REGISTRAR <b>DATE AUG 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10773

DEPARTMENT OF HEALTH

103 Washington St.

103 Washington St.

Nov. 17, 1907

Nov. 17, 1907

Commissioner, Department of Health

Commissioner, Department of Health

The City of New York

The City of New York

Office of the Commissioner

Office of the Commissioner

*[Handwritten signature]*

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*[Handwritten signature]*

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>		c. LENGTH OF STAY IN lb <b>1 Year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7331 Waldman Ave. 21219</b>				d. STREET ADDRESS <b>7331 Waldman Ave. 21219</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine M. Stritmater</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/81</b>		9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Donald Munroe</b>				14. MOTHER'S MAIDEN NAME <b>Mary Taylor</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>116-14-6679</b>		17. INFORMANT (Son) <b>Edgemere, Md. 21219</b> <b>Donald J. Stritmater, 7331 Waldman Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V-Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Serumity -</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Melvin B. Davis</b>		EXAMINER'S NAME (Type) <b>M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Morningside Rd.</b>		22. DATE SIGNED <b>8/7/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 9 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

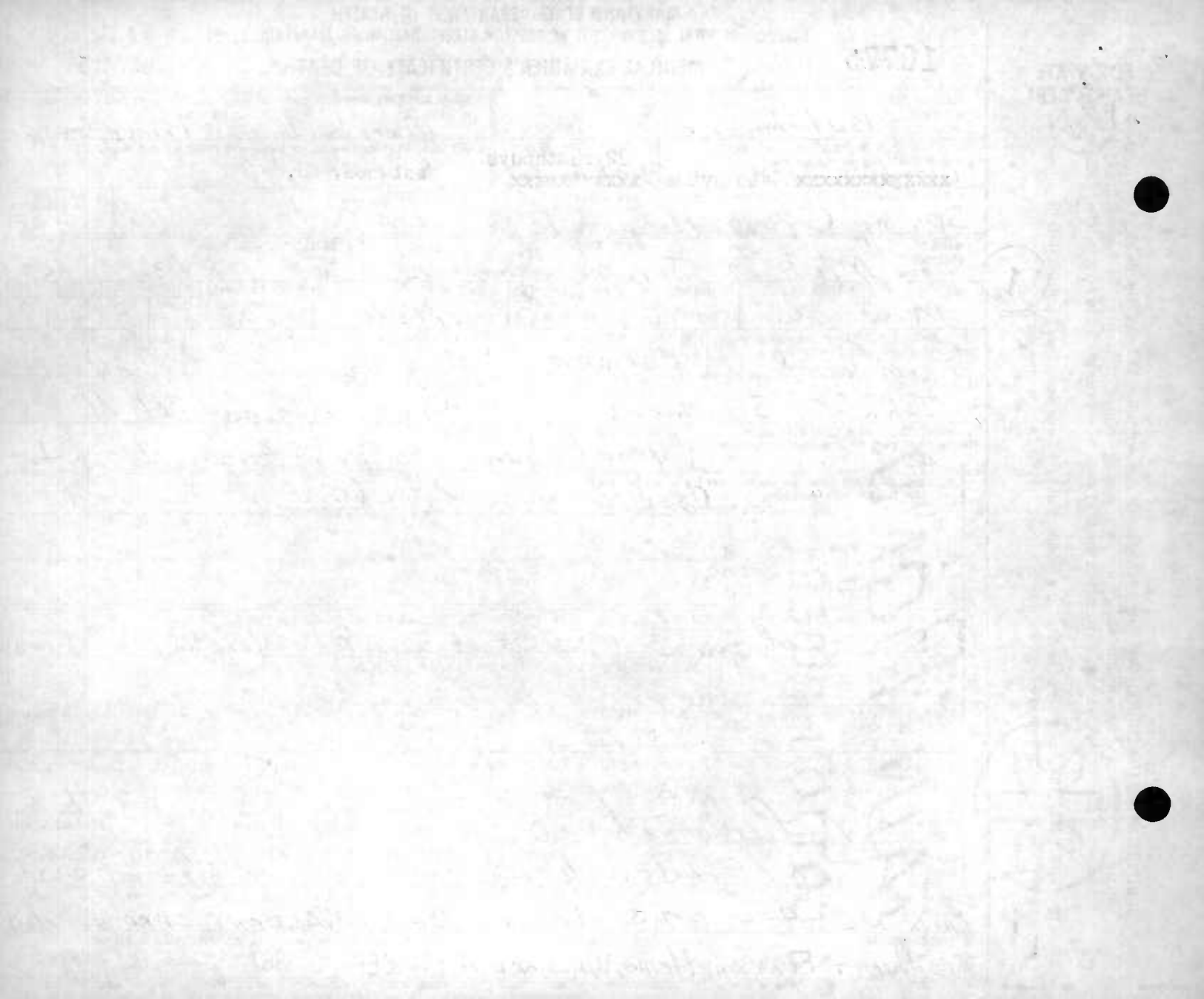
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westwood, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove Hospital</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) <u>Michael Jerome Summers</u>		4. DATE OF DEATH Month <u>8</u> / Day <u>31</u> / Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12/03</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John K. Summers</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Regina Hill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None Known</u>	
17. INFORMANT <u>Spring Grove Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4221</u> IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia (Patient at Spring Grove Hospital)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <u>8/31/67</u>		23. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u>		25. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
26. ADDRESS <u>The HUNTT FUNERAL HOME, WALDORF, MD.</u>		27. REC'D BY REGISTRAR DATE <u>SEP 6 1967</u>	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		29. DATE THEREOF <u>9-4-67</u>	
30. NAME OF CEMETERY OR CREMATORY <u>ST PETERS Cem.</u>		31. LOCATION (City or Town) (County) (State) <u>WALDORF CHARLES, MD.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10776					10776				
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>3 1/2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rosewood State Hospital</b>					d. STREET ADDRESS <b>R.D. #1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Carol</b>		Middle <b>Sue</b>		Last <b>SWOPE</b>		4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/21/62</b>		9. AGE (In years last birthday) <b>4</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LaVerne Swope</b>					14. MOTHER'S MAIDEN NAME <b>FANNON, Bertha F</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT Address <b>Rosewood Records, Owings Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7531 Congenital malformation of the brain</b> DUE TO (b) <b>Bronchopneumonia, bilateral</b> DUE TO (c) <b>Generalized convulsions</b>									INTERVAL BETWEEN ONSET AND DEATH <b>since birth</b> <b>6-days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> , 19 <b>63</b> , to <b>8/2/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/2/</b> 19 <b>67</b> , and that death occurred at <b>8:45</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>Hsu Ku-Shin Hsu</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Hsu Ku-Shin, M.D. M.D.</b>					22d. ADDRESS <b>Rosewood Lane, Owings Mills, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>8/5/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Branch Cemetery</b>			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>J. S. Myers Jr. Westminster, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 7 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>18 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto med Center</u>		d. STREET ADDRESS <u>604 South Linwood Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Victoria</u> First <u>Eva</u> Middle <u>SzumLanski</u> Last		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-03</u>
9. AGE (In years lost birthday) yrs. <u>63</u>		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTO-MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lisek</u>		14. MOTHER'S MAIDEN NAME <u>Magdaline Koscielniak</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-8133</u>	
17. INFORMANT (Husband) <u>John J. Szumlanski Sr.</u>		Address <u>Balto. Md.</u> <u>604 S. Linwood Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO (b) <u>CA of breast with long metastasis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8.4</u> , 19 <u>67</u> , to <u>8.22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8.22</u> , 19 <u>67</u> , and that death occurred at <u>5:55 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Rahim M. Bassiri</u>		22b. DATE SIGNED <u>8/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Rahim M. Bassiri</u>		22d. ADDRESS <u>Greater Balto. Med. Center, Towson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John J. Duda, 2829 Hudson St. Balto. Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10778

CERTIFICATE OF DEATH

10778

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>43 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>320 PHILADELPHIA BLVD</b>	
3. NAME OF DECEASED (Type or print) First <b>WILMER</b> Middle <b>C.</b> Last <b>TEAT</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-28-03</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CAB DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taxi Cab.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>SAVILLER TEAT</b>		14. MOTHER'S MAIDEN NAME <b>LUCINDA KNOTTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-05-8096</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia T.B., FAR ADVANCED, ACTIVE</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7-13-</b> , <b>1967</b> , to <b>8-24-</b> , <b>1967</b> , that (I) (we) last saw the deceased alive on <b>8-24</b> <b>1967</b> , and that death occurred at <b>2:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 27, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery.</b>		23d. LOCATION (City or Town) (County) (State) <b>Crumpton, Q.A. Md.</b>	
24. FUNERAL DIRECTOR <b>Edward Fellows</b>		25a. REC'D BY REGISTRAR <b>Millington, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>AUG 28 1967</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10779

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>218 Baltimore Ave.</u>		d. STREET ADDRESS <u>218 Baltimore Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Oskar</u> Middle <u>Terna</u> Last <u>Terna</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-1889</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. CITIZEN OF WHAT COUNTRY? <u>Estonia</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Estonia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Estonia</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>101260904</u>	
17. INFORMANT <u>Kaljo Popp</u>		Address <u>226 S. Oldham Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>A-S-C-V-Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD- 6800 Minerva Avenue</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>8-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Ruck</u>		22. DATE SIGNED <u>8/23/67</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10780

CERTIFICATE OF DEATH

10780

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>304</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>12 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>3721 E. PRATT STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>A.</b> Last <b>THAWLEY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>17</b> Year <b>19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 18, 1912</b>
9. AGE (In years last birthday) yrs. <b>55</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DIE SETTER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL THAWLEY</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MARY FREEDA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>215 01 83 54</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b> DUE TO <b>5810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CIRRHOSIS OF LIVER</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PEPTIC ULCER. HYPERTENSIVE HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/5/67</b> , 19__, to <b>8/17/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/17/67</b> , 19__, and that death occurred at <b>1:00AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ahmed Kutty</b>		22b. DATE SIGNED <b>8/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>AHMED C. K. KUTTY, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>F. Fisher</b>		25a. REF. BY REGISTRAR <b>AUG 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>F. Fisher</b>		25c. DATE <b>1930 EASTERN AVENUE, BALTIMORE, MD.</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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CHARGE

SECTION

INVESTIGATION

DATE

FILE NO.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item #2c & d Film #G392 8/28/67 ph											
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10781											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>					c. LENGTH OF STAY IN 1b						
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 21229</u>					d. STREET ADDRESS <u>4 Cromarty Rd.</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House In the Pines (Nursing Home)</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>V.</u> Last <u>Thomas</u>					4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO.-MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Late - Albert C. Thomas</u>					14. MOTHER'S MAIDEN NAME <u>Late - Sarah V. -----</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Harry Altvater</u>		Address <u>4 Cromarty Rd. - 21228</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial Infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u> DUE TO <u>-----</u> (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u> (b) <u>-----</u> (c) <u>-----</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>6-9</u> , 19 <u>67</u> , to <u>present</u> , 19 <u>---</u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>4:AM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>L. Kemper Owens</u> M.D.					ADDRESS (Street, city or town, state) <u>6 E. Road St., Baltimore, Md.</u>						
DATE SIGNED <u>8-22-67</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/24/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F. D. - 4101 Edmondson Av.</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 23 1967</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

CERTIFICATE OF DEATH

12781

<p>1. Name of deceased: <i>John A. Smith</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1900</i></p>	
<p>5. Place of birth: <i>Baltimore, Md.</i></p>		<p>6. Date of death: <i>Dec 10, 1945</i></p>	
<p>7. Cause of death: <i>Heart disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>John A. Smith</i></p>		<p>10. Signature of registrar: <i>John A. Smith</i></p>	
<p>11. Date of registration: <i>Dec 15, 1945</i></p>		<p>12. Office of registration: <i>Baltimore</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4602 Furley Ave. Balto, MD, MD</u>	
c. LENGTH OF STAY IN lb <u>4 DAYS</u>		d. STREET ADDRESS <u>4602 Furley Ave. Balto, MD.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Helen Lorena</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Can.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-11-95</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Lentgraf (Dec.)</u>		14. MOTHER'S MAIDEN NAME <u>KUTL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>MA.</u>	
17. INFORMANT <u>Admission Sheet</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Bilateral pleural effusion</u> DUE TO (c) <u>Ca of breast w metastasis to lung?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>8-18</u> , 19 <u>67</u> , to <u>8-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-22</u> , 19 <u>67</u> and that death occurred at <u>2:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Jose M. de Leon</u>		22b. DATE SIGNED <u>8-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u>		22d. ADDRESS <u>  </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-26-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore City Md.</u>
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>AUG 28 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
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1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 30-4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Chesapeake Manor Nursing Home</b>					d. STREET ADDRESS <b>909 Beaumont Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Helen F. Thompson</b>					4. DATE OF DEATH Month Day Year <b>August 29 19 67</b>				
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/25/1888</b>		9. AGE (In years last birthday) <b>79</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frames</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-03-3441R</b>		17. INFORMANT Address <b>Stanton, Conn.</b> <b>R. B. Thompson, 315 Emory Drive,</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diverticulosis</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>62</b> , to <b>Aug. 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Aug. 27, 1967</b> , and that death occurred at <b>7:42 M.</b> from causes and on the date stated above.									
22a. SIGNATURE <i>Lloyd E. Saylor</i>					22b. DATE SIGNED <b>Aug. 29, 1967</b>			22c. PHYSICIAN'S NAME (Type) <b>Dr. Lloyd E. Saylor</b>	
22d. ADDRESS <b>3902 Greenmount Ave.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/31/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md.</b>					25a. REC'D BY REGISTRAR DATE <b>SEP 1 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

10784		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10784	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GREATER BALT MEDICAL CENTER</b>				d. STREET ADDRESS <b>25 Haddington Road</b> <b>TOWSON, MARYLAND 21204</b>	
3. NAME OF DECEASED (Type or print) <b>Joseph Joseph</b>		First <b>ARDEL</b> Middle <b>THIRIFT</b> Last <b>THIRIFT</b>		4. DATE OF DEATH Month <b>AUG</b> Day <b>21</b> Year <b>1967</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-2-1915</b>		9. AGE (In years lost birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operation</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HUMBLE OIL CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TUCKER HILL, VA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>IRVING THIRIFT</b>		14. MOTHER'S MAIDEN NAME <b>VIOLA SPILMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>225-09-8488</b>		17. INFORMANT Address <b>CORNELIA CARTER THIRIFT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Hodgkin's disease with Radiation therapy</b> DUE TO (c) <b>Hodgkin's disease with Radiation therapy</b>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/16</b> , 19 <b>67</b> , to <b>8/</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>8</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Derek A Bruce</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DEREK A. BRUCE</b>		22d. ADDRESS <b>G. B. M. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 23, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westhampton Memorial Park</b>	
23d. LOCATION (City or Town) (County) (State) <b>Richmond, Virginia</b>		24. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>			
25a. REC'D BY REGISTRAR <b>AUG 24 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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UNITED STATES

DEPARTMENT OF THE ARMY

WASHINGTON

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CERTIFICATE OF DEATH

10785

10785

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1911 Walnut Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>HARRISON FRANCIS TOLLEY</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> Year <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Sewers</b>	9. AGE (In years last birthday) yrs. <b>59</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harrison F. Tolley</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Rigney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>438 03 50 57</b>	
17. INFORMANT <b>Clinical Recds VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO (c) <b>THROMBOSIS OF THE LEFT MIDDLE CEREBRAL ARTERY</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 8</b> , 19 <b>67</b> , to <b>Aug. 11</b> , 19 <b>67</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 11</b> , 19 <b>67</b> , and that death occurred at <b>7.45M</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Deogracias V. Faustino M.D.</i>		22b. DATE SIGNED <b>8/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DEOGRACIAS V. FAUSTINO, M.D.</b>		22d. ADDRESS <b>VA Hospital, Fort Howard, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/15/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>
24. FUNERAL DIRECTOR <b>DUDAS FUNERAL HOME, WISE AVE. BALTIMORE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TABLE 3

*(continued from page 6)*

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN lb <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto County General Hospt.</u>		d. STREET ADDRESS <u>2617 Poplar Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Rebra</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) yrs. <u>70</u>
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Chernoff</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-48-5424</u>	17. INFORMANT <u>Mrs. Norma Moritz, 2617 Poplar Drive</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> , 19 <u>67</u> , to <u>8-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-1</u> , 19 <u>67</u> , and that death occurred at <u>9:20 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. Khader</u>		22b. DATE SIGNED <u>8/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. Khader</u>		22d. ADDRESS <u>Baltimore County General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Arlington)</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>AUG 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>

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Elko County General Hospital

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10787

Item #9 Film #G-392 9/11/67

## CERTIFICATE OF DEATH

10787

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN lb <b>3 mos. 25 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		072	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>RD 1, Box 17-A</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES WILLIAM TOWNLEY</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>1967</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8-7-07</b>
9. AGE (In years) <b>60</b> (last birthday) <b>34 1/2</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>ANDREW TOWNLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY U. BROOKS.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-07-1370</b>	
17. INFORMANT <b>Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO <b>163 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>post operative status of left upper lobectomy due to cancer.</b> DUE TO <b>Hydropneumothorax.</b> (c) <b>Hydropneumothorax.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-3-</b> , 1967, to <b>8-28-</b> , 1967, that (I) (we) last saw the deceased alive on <b>8-28</b> , 1967, and that death occurred at <b>6:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Newcomer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Supt.</b>		22d. ADDRESS <b>Mt. Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/2/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jones Mem. Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Port Deposit, Md Rural</b>
24. FUNERAL DIRECTOR <b>Sec 9 Baltimore and Son Perryville Md</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Mr. William George Thompson

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Mr. William George Thompson

Mr. William George Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>Thornton Road RD</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Talbott</u> Last <u>Tracey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 17, 1910</u>
9. AGE (In years last birthday) yrs. <u>56</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Edward Freeland</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-28-9404</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - original</u> DUE TO (b) <u>resuscitation</u> DUE TO (c) <u>no cause</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>no</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 28, 1967</u> , to <u>Aug 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 4, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell</u>		22b. DATE SIGNED <u>8-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Reisterstown, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 8, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Jessop's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10008

STATE OF DEAN

THE STATE OF DEAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10789			
CERTIFICATE OF DEATH			
10789			
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brooklandville</u>		c. LENGTH OF STAY IN lb <u>Rural Brooklandville, Md.</u> 03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Valley Road, Brooklandville, Md.</u>		d. STREET ADDRESS <u>Valley Road</u>	
3. NAME OF DECEASED (Type or print) <u>David Milton Trager, Br.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/89</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Trager</u>		14. MOTHER'S MAIDEN NAME <u>Mary Menchen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>212-07-3147</u>	
17. INFORMANT <u>Mr. David M. Trager, Jr.</u>		Address <u>Woodlawn, Md.</u> <u>2023 J. Woodlawn Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1967</u> , to <u>Aug. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1967</u> , and that death occurred at <u>830 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William A. Pillsbury</u>		22b. DATE SIGNED <u>8-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		22d. ADDRESS <u>TIMONIUM, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug. 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville 8, Md.</u>
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Pikesville 8, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>AUG 11 1967</u>			

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10790

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Md. #8</u>		c. LENGTH OF STAY IN lb <u>3 da.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3306 Janelle Drive</u>		e. STREET ADDRESS <u>3306 Janelle Dr</u>	
3. NAME OF DECEASED (Type or print) <u>DORRIS VIRGINIA TRAVERS</u>		4. DATE OF DEATH <u>Aug 21 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-7-14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>	9. AGE (In years lost birthday) <u>52</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wilbert H. Travers Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Williamina Morgan?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-30-0977</u>	
17. INFORMANT <u>Wilbert H. Travers Jr.</u>		Address <u>7 Kinross Ave - Glen Burnie</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None.</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None.</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Catles</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CATLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Aug 24 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Burnie Md</u>
24. FUNERAL DIRECTOR <u>Engle B. Flamm</u>		25a. REC'D BY REGISTRAR <u>DATE AUG 23 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are visible.]*

Printed by the Government of the State of New York  
at the State Printing Office, Albany, 1880.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10791

CERTIFICATE OF DEATH

10791

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FULLERTON</u> <u>03, 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ST. JOSEPH HOSP</u> <u>DOA.</u>		d. STREET ADDRESS <u>7855 BELAIR ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>THEODORE</u> First <u>TRUSS</u> Middle Last		4. DATE OF DEATH <u>AUGUST</u> <u>30</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3</u> 19 <u>1919</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION REPAIR</u>	9. AGE (In years lost birthday) <u>48</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THEODORE TRUSS</u>		14. MOTHER'S MAIDEN NAME <u>HELEN L. LENTOWSKI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-01-7650</u>	
17. INFORMANT <u>HELEN TRUSS</u>		Address <u>7855 BELAIR RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive arteriosclerotic Cardiovascular Disease</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) <u>Chronic Myocardial infarction with failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>
20f. (City or town) (County) (State) <u></u>			
21. I certify that (I) (this hospital) attended the deceased from <u>June 28</u> , 19 <u>66</u> to <u>Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 28</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Frank T. Kasik Jr. M.D.</u>		22b. DATE SIGNED <u>8/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR. M.D.</u>		22d. ADDRESS <u>9005 HARFORD ROAD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. CO. MD</u>	
24. FUNERAL DIRECTOR <u>DIPPEL BROTHERS INC</u>		24a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
ADDRESS <u>7106 BELAIR RD. 21206</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10792

CERTIFICATE OF DEATH

10792

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>QUEEN ANNE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>CHESTER</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN W. TULL</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 9, 1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATERMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FISHING</b>	9. AGE (In years lost birthday) yrs. <b>42</b>
11. BIRTHPLACE (County & State, or foreign country) <b>CHESTER, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE S. TULL</b>		14. MOTHER'S MAIDEN NAME <b>ANNA M. THOMPSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>215 20 04 95</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF THE LARYNX</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FEMORAL ARTERY OCCLUSION OR EMBOLISM</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/7/67</b> , 19____, to <b>8/10/67</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/10/67</b> , 19____, and that death occurred at <b>1:40AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>George C. McElpatrick</i> M.D.		22b. DATE SIGNED <b>8/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE C. MC ELPATRICK, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>Aug. 13</b>	23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>STEVENSVILLE, MARYLAND</b>
24. FUNERAL DIRECTOR <i>Edgar Lane</i>		25a. REC'D BY REGISTRAR <b>EDGAR LANE FUNERAL HOME</b> DATA <b>AUG 15 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

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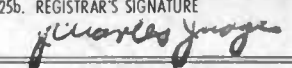
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

10793

10793

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St Joseph Hospital</b>		d. STREET ADDRESS <b>426 E. Lake Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Myron Griffin Tull</b>		4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1889</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Thomas Tull</b>		14. MOTHER'S MAIDEN NAME <b>Helen Robinson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>220-44-4113 T</b>	17. INFORMANT Address <b>Mrs. Ella Nora Baer Tull Same</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/14</b> , 19 <b>67</b> , to <b>8/18</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/18</b> , 19 <b>67</b> , and that death occurred at <b>9:03 p.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE 		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <b>8/18/67</b>
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ismael Jamora M.D.</b>		22d. ADDRESS <b>St. Joseph Hospital</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-21-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge</b>	23d. LOCATION (City or Town) (County) (State) <b>Delta, Penna.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 21 1967</b>	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10794

CERTIFICATE OF DEATH

10794

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>2yr11mth6dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace, Maryland</b>		12.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>300 St. John St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>KATHERINE</b> Last <b>Turner</b>		4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1913</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min. <b>53</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William Fox</b>		14. MOTHER'S MAIDEN NAME <b>Carrie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>UNK</b>		16. SOCIAL SECURITY NO. <b>UNK</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of liver, mild - chronic alcoholism</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 23, 1964</b> to <b>Aug. 29, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 29, 1967</b> , and that death occurred at <b>8:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Stella Wachslar</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M.D.</b>		22b. DATE SIGNED <b>8-29-67</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/31/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Havre de Grace Harford Md</b>	
24. FUNERAL DIRECTOR <b>Cunningham &amp; Son</b>		ADDRESS <b>Havre de Grace Md</b>	
25a. REC'D BY REGISTRAR <b>SEP 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10795

10795

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr10mth11dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea, Maryland</b>		d. STREET ADDRESS <b>3819 Glenarm Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Aven Tysor</b>		4. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1896</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 Year Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Apt. Building</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles Tysor</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Morelen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>C 3 061 753 Navy WWI</b>		16. SOCIAL SECURITY NO. <b>217-20-1419</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral, organism unknown</b> DUE TO (b) <b>Bronchiectasis, chronic</b> DUE TO (c) <b>3 years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Oct. 9, 1964</b> to <b>Aug. 20, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 20, 1967</b> , and that death occurred at <b>10:55</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-21-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/23/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Anne Arundle Co., Md.</b>	
24. FUNERAL DIRECTOR <b>James E. Bruzdinski</b>		25a. REC'D BY REGISTRAR <b>AUG 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>1407 Eastern Ave. Balto. 21</b>	

64502



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

FOR STATE  
HEALTH DEPT

State Department of Health

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> c. LENGTH OF STAY IN It <b>03 1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Baltimore County General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>8033 Woodgate Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALAN</b> First Middle Last <b>R. UMIN</b>		4. DATE OF DEATH Month Day Year <b>August 13, 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1950</b> 9. AGE (In years last birthday) yrs. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Joseph Louis Umin</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Oninberg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Joseph L. Umin, 8033 Woodgate Court</b>	
17. INFORMANT <b>Mr. Joseph L. Umin, 8033 Woodgate Court</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hanging</b> DUE TO (b) <b>974X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>974X</b> DUE TO (c) <b>974X</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hung self</b>	
20c. TIME OF INJURY Month, Day, Year <b>10 XXXXX 8/13 19 67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> ot work ot work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In-Laws Home</b>	
20f. (City or town) (County) (State) <b>Baltimore, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> EXAMINER'S NAME (Type)		22. DATE SIGNED <b>8/14/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/15/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mikro Kodesh Beth Israel</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros. Inc., 6010 Reist.,</b>		25a. REC'D BY REGISTRAR <b>AUG 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10750

APR 1, 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10797

CERTIFICATE OF DEATH

10797

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>				d. STREET ADDRESS <b>423 Hutchins Ave. #21212</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold Seymour Vassar</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>September 4, 1912</b>		9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bugle Laundry</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bugle Laundry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNK.</b>				14. MOTHER'S MAIDEN NAME <b>ROSE VASSAR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>225-03-0366</b>		17. INFORMANT <b>Mrs. Mildred Vassar</b> Address <b>423 Hutchins Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetic Acidosis</b> DUE TO (c) <b>Pneumonia</b> (d) <b>Urinary tract infection</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>12:23 AM</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 29, 1967</b> , to <b>August 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>August 29, 1967</b> , and that death occurred at <b>12:23 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Teodula Paglinauan, Jr.</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>August 29, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Teodula Paglinauan, Jr.</b>				22d. ADDRESS <b>7620 York Road, Towson, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-2-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens Street</b>				25a. REC'D BY REGISTRAR <b>SEP 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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(b)

*Handwritten signature: J. M. [illegible]*

Name \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3452 Auchentoroly Terrace</b>	
3. NAME OF DECEASED (Type or print) <b>CLARENCE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1894</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>19 67</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Northumberland, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Venie</b>	
14. MOTHER'S MAIDEN NAME <b>Sally Urby</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>216-12-73-09</b>		17. INFORMANT <b>Clin. Rec. VAH, Fort Howard, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF PROSTATE WITH METASTASIS</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN DEATH AND DEATH <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHOPNEUMONIA. GENERALIZED ARTERIOSCLEROSIS</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <b>he</b> (this hospital) attended the deceased from <b>August 15, 1967</b> , to <b>August 19, 1967</b> , that <b>he</b> (we) lost saw the deceased alive on <b>August 19, 1967</b> , and that death occurred at <b>4:00AM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>J. D. Talbert</b>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Earl Gilmore</b>		25a. REC'D BY REGISTRAR <b>AUG 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

Burial

Baltimore National Cemetery  
107 W. North Avenue  
Baltimore, Maryland  
August 1967

THE PORT HOWARD, MARYLAND

August 19 67

x

August 19 67  
11:00AM

x 67

SEPTEMBER 1967

XX

Yes

WW I

810-12-13-02

CLIN. REC. VAN, FORT HOWARD, MARYLAND

John Venie

Sally Gray

Cook

Northumberland, Virginia

U.S.A.

Male

Colored

XX

June 1, 1894

WMD

AUGUST

19

67

Baltimore

Maryland

Ford Howard

4 Days

Baltimore

Veterans Administration Hospital

3822 Annapolis Avenue



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <u>28</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville, Md. 28</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home - 327 N. 215 W. Saratoga St.</u>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Maryland</u> d. STREET ADDRESS <u>304</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bessie M. Wales</u> First Middle Last					<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>14</u> Year <u>1967</u>				
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>11/2/1869</u>		<b>9. AGE (in years last birthday)</b> <u>98</u> yrs. IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>William Wolgram</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilhelmina ?</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>					<b>16. SOCIAL SECURITY NO.</b>				
<b>17. INFORMANT</b> <u>Mr. Edgar F. Wales</u>					<b>18. ADDRESS</b> <u>2016 France St. Philadelphia, Pa.</u>				
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO (b) <u>Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Extreme Senility</u>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Years</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>ASCVD - Senile Dementia - Multiple Decubiti</u>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10-16-</u>, 19<u>62</u>, to <u>8-14-</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>8-14-</u>, 19<u>67</u>, and that death occurred at <u>9:15</u> M, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Cesar Valle Caverio</u>					<b>22b. DATE SIGNED</b> <u>8-14-67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>CESAR VALLE CAVERIO</u>		
<b>22d. ADDRESS</b> <u>8629 Liberty Rd</u>					<b>22e. REC'D BY REGISTRAR</b> <u>1000 J. Fickenshoron North, Pa.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>8/17/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cemetery</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Baltimore, Md.</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Wm. J. Fickenshoron North, Pa.</u>					<b>25a. REC'D BY REGISTRAR</b> <u>AUG 22 1967</u>				
<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>									

MEDICAL CERTIFICATION

STATE OF TEXAS  
COUNTY OF DALLAS

IN SENATE

REPORT

OF THE  
COMMISSIONERS OF THE  
LAND OFFICE

FOR THE YEAR 1881

1881

1881

1881

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10800 Item #7 Film #392 9/15/67 pp 10800											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 47 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 30.4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dulaney T owson Nursing home						d. STREET ADDRESS Marylander Apts.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last RACHEL LANGMEADE WALLIS						4. DATE OF DEATH Month Day Year August 31, 1967					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1906		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sales Manager				10b. KIND OF BUSINESS OR INDUSTRY Importing Firm		11. BIRTHPLACE (County & State, or foreign country) London, England			12. CITIZEN OF WHAT COUNTRY? England		
13. FATHER'S NAME Isaac Levy						14. MOTHER'S MAIDEN NAME Esther Greenberg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-30-3510		17. INFORMANT Mrs. Mickey Cox, 305 W. 52st. Street, New York, New York 10019					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: widespread metastatic carcinoma due to adenocarcinoma of breast IMMEDIATE CAUSE (a) 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 14 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Edwin H. Stewart, Jr. M.D.</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/31/67			
22c. PHYSICIAN'S NAME (Type) Edwin H. Stewart, Jr. M.D.						22d. ADDRESS 721 Medical Arts Bldg Baltimore, Maryland 21201					
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION				23b. DATE THEREOF SEPT. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY			23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR WM. COOK-BROOKS TOWSON, 1050 YORK ROAD TOWSON, MARYLAND						25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10801

Item #9 Film #G391 8/14/67 ph

CERTIFICATE OF DEATH

10801

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb <b>Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1202 Culvert Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY E. WALSTON</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>52 approx.</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Manager</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>W.W. Granger, Inc.</b>	
10a. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		10b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. FATHER'S NAME <b>Milton J. Walston</b>		12. MOTHER'S MAIDEN NAME <b>Edna Layfield</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		14. SOCIAL SECURITY NO. <b>217-03-0489</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Cerebral Insufficiency</b> DUE TO (b) <b>Arterial H.D.</b> DUE TO (c) <b></b>		16. INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		17b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
18a. TIME OF INJURY Hour <b>a.m.</b> Month <b>19</b> Day <b>19</b> p.m.	18b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	18c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	18d. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>67</b> to <b>Aug</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/1</b> , 19 <b>67</b> , and that death occurred at <b>7:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. Edward Leach</b>		22b. DATESIGNED <b>8/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. Edward Leach</b>		22d. ADDRESS <b>14 E. Eager St., Baltimore, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 10, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cockeysville, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 10 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
20M 1/65

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10802 CERTIFICATE OF DEATH 10802											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville Md</u>				c. LENGTH OF STAY IN 1b <u>25 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradshaw Rd.</u>						d. STREET ADDRESS <u>Bradshaw Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Wilber</u> Last <u>Waltmeyer</u>						4. DATE OF DEATH Month <u>Aug</u> Day <u>14</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>03</u> Days <u>11</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Pattern Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furn. Empich</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John Woodman Waltmeyer</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Daisy Hines</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>02097917</u>		17. INFORMANT <u>Alverta C. Waltmeyer</u> Address <u>Bradshaw Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malignant Hypertension</u> 4457 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , to <u>Aug.</u> , 1967, that (I) (we) last saw the deceased alive on <u>Aug 12 1967</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William A. Tyson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-14-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. TYSON</u>						22d. ADDRESS <u>Kingsville Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/17/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>				23d. LOCATION (City, town or county) (State) <u>TRUMPS MILL RD MD</u>			
24. FUNERAL DIRECTOR <u>DIPPEL BROS INC 710 BELAIR RD</u>						25a. REC'D BY REGISTRAR <u>AUG 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

5420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10803

CERTIFICATE OF DEATH

10803

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1317 Elm Road</b>		d. STREET ADDRESS <b>1317 Elm Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EUGENE E. WATTS, JR.</b> First Middle Last		4. DATE OF DEATH <b>August 27,</b> Month Day Year 19 <b>67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-23-1955</b> 9. AGE (In years lost birth day) yrs. <b>12</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eugene E. Watts, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Thelma Herold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Eugene E. Watts, Sr.</b>		Address <b>1317 Elm Road</b> <b>21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C. N. S. Degeneration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hydrocephaly</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Life</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>Willard E. Standiford</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Willard E. Standiford</b>		22d. ADDRESS <b>6630 Baltimore National Pike</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8-30-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

1000

STATE OF TEXAS

County of ... State of Texas  
Know all men by these presents, that ...  
for and to the use of ...  
the sum of ... Dollars  
to have and to hold unto the said ...  
his heirs and assigns forever ...  
Witness my hand and seal of office this ... day of ... A.D. 19...  
at the City of ... State of Texas  
Notary Public in and for the State of Texas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10804

CERTIFICATE OF DEATH

10804

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>2537 - A Gatehouse Drive #21207</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Weber</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28, 1967</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>22</b> IF UNDER 1 YEAR Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Joseph F. Weber</b>		14. MOTHER'S MAIDEN NAME <b>Laura J. Kokula</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sclerema neonatorum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 28, 1967</b> , to <b>August 19, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 19, 1967</b> , and that death occurred at <b>2:30 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Jose A. Aguto</b>		22b. DATE SIGNED <b>August 19, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jose A. Aguto, M.D.</b>		22d. ADDRESS <b>7620 York Rd, Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/21/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Joseph N. Zannino 263 S. Conkling Street</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 29 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

MEDICAL CERTIFICATION

1000

EXHIBIT 1000

1000

1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

10805

10805

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		c. LENGTH OF STAY IN lb <u>BALTIMORE MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>		d. STREET ADDRESS <u>7830 OAKLEIGH ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>MAE</u> Last <u>WEBER</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-09</u>
9. AGE (In years, lost birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS B. NEWCOMB</u>		14. MOTHER'S MAIDEN NAME <u>ANNA E. <del>NEWCOMB</del> HADDAWAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no UNK</u>		16. SOCIAL SECURITY NO. <u>212-26-5612</u>	
17. INFORMANT <u>John Raymond Weber--7830 Oakleigh Rd., Balto</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute yellow atrophy, liver</u> DUE TO (b) <u>Infectious hepatitis (?)</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>092X</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>67</u> , to <u>8/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/26</u> , 19 <u>67</u> , and that death occurred at <u>10:04 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>RBreiteneder</u>		22b. DATE SIGNED <u>8/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GBMC</u>		22d. ADDRESS <u>GBMC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>8-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc....Baltimore, Md....14</u>		25a. RECEIVED BY REGISTRAR <u>AUG 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10308

CONTINUED ON REVERSE

Land County, WI.

2/26 67 2/17 67 2/26 67 2/26 67

Isaacson J. Fred. Inc. .... Baltimore, Md. ....  
Isaacson J. Fred. Inc. .... Baltimore, Md. ....  
Isaacson J. Fred. Inc. .... Baltimore, Md. ....

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10806

CERTIFICATE OF DEATH

10806

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>				d. STREET ADDRESS <u>3655 Forest Hill Road #7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irving Weksler</u>				4. DATE OF DEATH <u>August 10 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>25 Dec 1893</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Weksler</u>				14. MOTHER'S MAIDEN NAME <u>Rose</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Mrs. Mary Weksler, 3655 Forest Hill Road #7</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. (b) <u>3 1/2 yrs</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 1964</u> to <u>10 Aug 1967</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>10 Aug 1967</u> and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Marvin Davis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11 Aug 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Marvin Davis</u>				22d. ADDRESS <u>6512 Liberty Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Arlington)</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>				25a. REC'D BY REGISTRAR <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

6130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10807

CERTIFICATE OF DEATH

10807

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>30 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2727 W. GARRISON AVENUE</b>	
3. NAME OF DECEASED (Type or print) <b>(WILLIAM) WILLIE STOKES WELLS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/11/96</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>36</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>ROSEHILL, NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANDREW WELLS</b>		14. MOTHER'S MAIDEN NAME <b>LUCY CARR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> WW I		16. SOCIAL SECURITY NO. <b>216 01 80 12</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE. EMPHYSEMA, OBSTRUCTIVE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE. EMPHYSEMA, OBSTRUCTIVE</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <input checked="" type="checkbox"/> this hospital attended the deceased from <b>7/23/67</b> , 19__, to <b>8/22/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/22/67</b> , 19__, and that death occurred at <b>3:45AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John D. Talbert</b>		22b. DATE SIGNED <b>8/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>Charles R. Law</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>		25c. REGISTRAR'S SIGNATURE <b>Charles R. Law</b>	

10801

BALTIMORE

BALTIMORE

PORT HOWARD

30 1-15

BALTIMORE 21515

FEDERAL ADMINISTRATIVE HOSPITAL

2007 W. GARRISON AVENUE

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WILLIS

APRIL 22 1967

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WHITE

BALTIMORE

2007 W. GARRISON AVENUE

ANDREW WILLIS

WILLIS

WILLIS

30 1-15

2007 W. GARRISON AVENUE, BALTIMORE, MD.

CENTRAL TELEPHONE

CENTRAL TELEPHONE

INTERCOMMODITY HEART DISEASE, HYPERTENSION, CORONARY

8/25/67

8/25/67

8/25/67

8/25/67

WILLIS

WILLIS

BALTIMORE

BALTIMORE

BALTIMORE

BALTIMORE

8/25/67

BALTIMORE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10808

CERTIFICATE OF DEATH

10808

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. LENGTH OF STAY IN 1b <b>Relay</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1530 Rolling Road</b>		d. STREET ADDRESS <b>1530 Rolling Road</b>	
3. NAME OF DECEASED (Type or print) <b>Ralph D. Wheeler, Sr</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/3/93</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Lena Atz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-8459</b>	
17. INFORMANT <b>Mrs. Annie M. Wheeler, 1530 Rolling Rd.</b>		Address <b>21227</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulatory Failure</b> DUE TO (b) <b>Arterial C.V.D.</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> , 19 <b>66</b> to <b>8/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/8</b> , 19 <b>67</b> , and that death occurred at <b>8:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. Edward Leach</b>		22b. DATE SIGNED <b>8/10/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. C. Edward Leach</b>		22d. ADDRESS <b>14 E. Eager St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/11/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 14 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

100-100000  
100-100000

TO : DIRECTOR, FBI (100-100000)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with multiple paragraphs and possibly a signature block at the bottom.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>CELENSVILLE</u>		c. LENGTH OF STAY IN lb <u>9 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE S. Hospital</u>		d. STREET ADDRESS <u>227 N FULTON AVE</u>	
3. NAME OF DECEASED (Type or print) <u>NATHANIEL</u> First Middle Last <u>WICKS</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/21/1900</u>
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS MARY L WICKS</u>		Address <u>227 N FULTON AVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO <u>Heart FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis heart disease</u> (c) <u>CHRONIC BRAIN SYNDROME</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC BRAIN SYNDROME</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>67</u> , to <u>8/5/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/5</u> , 19 <u>67</u> , and that death occurred at <u>7 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> MD		22b. DATE SIGNED <u>8/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EVELIO A. FELIPE MD</u>		22d. ADDRESS <u>SPRING GROVE S. Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-9-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Memorial Park Baltimore City</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore City</u>
24. FUNERAL DIRECTOR <u>Marion J. Dyett</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10810

10810

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>30-4</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, 7620 York Rd.</b>		d. STREET ADDRESS <b>920 S. Highland Av. 21224</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN H. WILLEY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/19/03</b>
9. AGE (In years lost birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crown, Cork &amp; Seal</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Willey</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Hartman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-0805</b>	
17. INFORMANT <b>Nellie M. Willey</b>		Address <b>Same.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b> DUE TO (b) <b>0021</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>it</b> (this hospital) attended the deceased from <b>August 18, 1967</b> , to <b>August 18, 1967</b> , that <b>it</b> (we) last saw the deceased alive on <b>August 18, 1967</b> , and that death occurred at <b>7:45 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence F. Misanik, M. D.</b>		22b. DATE SIGNED <b>August 19, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence F. Misanik, M. D.</b>		22d. ADDRESS <b>7620 York Road Towson 4, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>7225 Eastern Blvd. Ba. Co., Md.</b>
24. FUNERAL DIRECTOR <b>Charles S. Jailer</b>		25a. REG'D BY REGISTRAR <b>AUG 22 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jailer</b>			

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RECORDS OF THE

Charles Willey

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Willey, Charles

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10811		CERTIFICATE OF DEATH	
10811		10811	
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>---</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
c. LENGTH OF STAY IN 1b <b>34 DAYS</b>		d. STREET ADDRESS <b>2820 BAKER STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES M. WILLIAMS</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 30, 1927</b>
9. AGE (In years last birthday) yrs. <b>40</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PORTER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES L. WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN BYRD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES PL 28</b>		16. SOCIAL SECURITY NO. <b>212 22 13 89</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC RENAL DISEASE, PROBABLE GLOMERULONEPHRITIS 10 YEARS</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADVANCED UREMIC SYNDROME</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/11/67</b> , 19 <b>to 8/13/67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/13/67</b> , 19 <b>and that death occurred at 11:40 P</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Ahmed Kuty</b>		22b. DATE SIGNED <b>8/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>AHMED C. K. KUTTY, M. D.</b>		22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR <b>6014/L 8011</b>		25a. REC'D BY REGISTRAR <b>Aug 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

INSTITUTION OF HEALTH

1831

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10812

CERTIFICATE OF DEATH

10812

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>12 yrs</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2511 Burrridge road</b>				d. STREET ADDRESS <b>2511 Burrridge road</b>	
3. NAME OF DECEASED (Type or print) <b>ROSE B WILLIAMS</b>		First Middle Last		4. DATE OF DEATH <b>Aug 20 19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 19 1913</b>		9. AGE (In years last birthday) <b>53 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Charles F. Maguire</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family records</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August 1965</b> to <b>Aug-20, 1967</b> that (I) (we) last saw the deceased alive on <b>Aug-15 1967</b> and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <b>A Myrton Gaines Jr.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/21/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Myrton L. Gaines Jr. M.D.</b>		22d. ADDRESS <b>7800 York road</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/23/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto Co Md.</b>	
24. FUNERAL DIRECTOR <b>C.F.EVANS &amp; SON 8802 Harford Rd.</b>			25a. REC'D BY REGISTRAR <b>AUG 23 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

10812

Baltimore

Parkville

2511 Burdette Road

ROSE B WILLIAMS

XI

Dec 19 1912

At home

Charles F. Maguire

Scottish Locomotive

Family records

USA

New York

Aug 50

2511 Burdette Road

Parkville

Kennett

12 yrs

DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>5109 Eugene Avenue #21206</b>	
3. NAME OF DECEASED (Type or print) <b>Louis C. Winkelman</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1905</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self-Employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Winkelman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Schlunt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-1975</b>	
17. INFORMANT <b>Mrs. Rose M. Winkelman</b>		Address <b>(Same)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>157x</b> IMMEDIATE CAUSE (a) <b>Carcinomatosis - primary in pancreas.</b> DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 14, 1967</b> , to <b>August 22, 1967</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>August 22, 1967</b> , and that death occurred at <b>1:45 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez, M.D.</b>		22b. DATE SIGNED <b>August 22, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/25/67.</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 23 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			

Edward J. Hunt, Inc. Baltimore, Md. 21201

8/22/61 Holy Redeemer Cemetery

Baltimore, Md.

Technical Service Bureau, Inc.

1000 York Road, Baltimore, Md. 21206

August 22, 1961

1:15 PM

August 19, 1961

1000 York Road, Baltimore, Md. 21206

Enclosed please find check for \$100.00.

SIR:- Mrs. Rose M. Winkelman

(same)

Henry Winkelman

California Colonel

Self-employed

2100 York Road, Baltimore, Md. 21206

428

2000 York Road, Baltimore, Md. 21206

2100 York Road, Baltimore, Md. 21206

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

10814

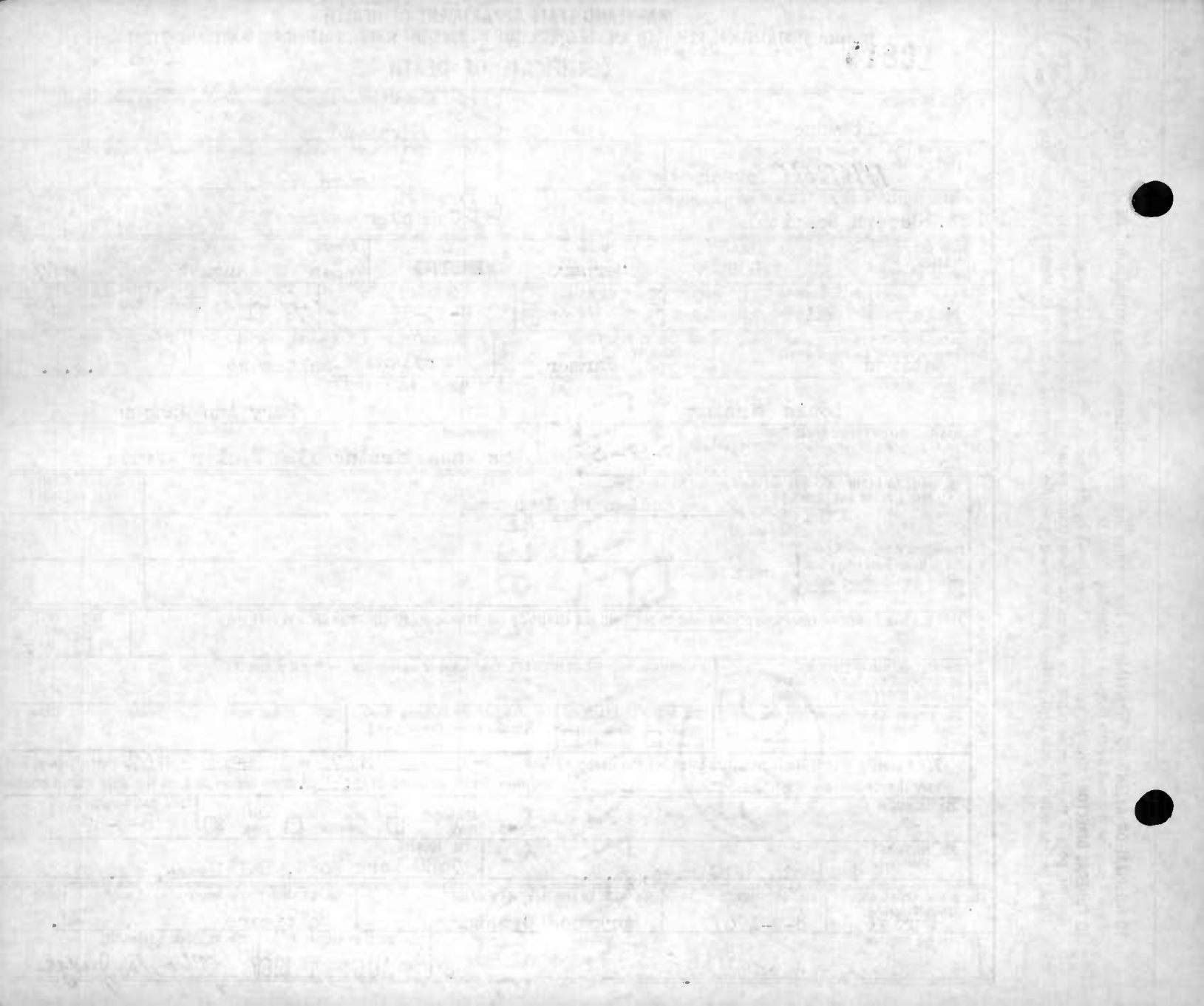
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G391 8/11/67 ph

# CERTIFICATE OF DEATH

10814

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balt</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>		d. STREET ADDRESS <b>4320 Necker Avenue #36</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>Bernard</b> Last <b>WIRSING</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-95</b>
9. AGE (In years) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Wirsing</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ann Jasper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-12-8332</b>	
17. INFORMANT <b>Mrs Anna Wirsing</b>		Address <b>4320 Necker Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant lymphoma</b> DUE TO <b>2002</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-6</b> , 19 <b>67</b> , to <b>8-6</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>8-6</b> 19 <b>67</b> , and that death occurred at <b>2:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin del Carmen</b> M.D.		22b. DATE SIGNED <b>8-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Benjamin delCermen, M.D.</b>		22d. ADDRESS <b>7620 York Road, Baltimore, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-9-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>36 710 Belair Road</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>AUG 8 1967</b>			



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1

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27

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10815

CERTIFICATE OF DEATH

10815

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>6 Hrs 25 Min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>9 S. Stockton Street</b>	
3. NAME OF DECEASED (Type or print) <b>FRED D. WISE</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>19 67</b>	
5. SEX <b>Male</b> <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
6. COLOR OR RACE		8. DATE OF BIRTH <b>9/15/96</b>	
9. AGE (In years last birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Shenandoah, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grant Wise</b>		14. MOTHER'S MAIDEN NAME <b>Lettie Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>220-07-20-24</b>	
17. INFORMANT <b>Clin. Rec. VA Hospital, Fort Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERALLY, UNDETERMINED ORGANISM</b> DUE TO <b>ENCEPHALOMALACIA, LEFT OCCIPUT;</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BASTIAR ARTERY ATHEROMATA</b> DUE TO (c) <b>CEREBRAL ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN DEATH AND DEATH <b>DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE, ARTERIOIAR NEPHROSCLEROSIS, ARTERIOSCLEROTIC HEART DISEASE, PULMONARY EMPHYSEMA</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/28/</b> , 19 <b>67</b> , to <b>8/28/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8/28</b> , 19 <b>67</b> , and that death occurred at <b>7:10 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lettie Wilson</b>		22b. DATE SIGNED <b>8/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>NEILON NEILSON, M. D.</b>		22d. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/1/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Hayes Funeral Home</b>		25a. REC'D BY REGISTRAR <b>638 N. Gilmore St. Baltimore, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 31 1967</b>	

Myers Funeral Home

Barrel

3/1/57

Baltimore National Cemetery  
638 N. Gilman St.  
Baltimore, Maryland

Baltimore, Maryland

NATIONAL CEMETERY, N. D. VA HOSPITAL, FORT HOWARD, MARYLAND

X 5/1/57

8/28 04

8/28/

7:10 PM

8/28/

01 X

AMERICAN BROTHERHOOD OF HORSEBOYERS  
MEMBER, AMERICAN BROTHERHOOD OF HORSEBOYERS

ONE YEAR ANNUAL DUES

FAMILY AGENT'S RECORD

THE BROTHERHOOD OF HORSEBOYERS

THE BROTHERHOOD OF HORSEBOYERS

Yes

WYI

220-07-20-21 Clin. Rec. VA Hospital, Fort Howard, Md.

Grant Wise

Lothe Wilson

Cook

800 Railroad

Shenandoah, Virginia

U.S.A.

Male Colored

XX

RED

D.

WBS

AUGUST

28

07

Fort Howard & Mrs. S. W.

Baltimore

Baltimore

Maryland

10815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10816			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>21205</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital, 7620 York Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM H. WOHNER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1882</b>
9. AGE (In years lost birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>August A. Wohner</b>		14. MOTHER'S MAIDEN NAME <b>Mary Manlin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-09-4127A</b>	
17. INFORMANT <b>Mr. George Wohner</b>		Address <b>5347 Stuyvesant</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of basilar artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Infarction of pons</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from <b>August 18, 1967</b> to <b>August 22, 1967</b> , that (x) (we) last saw the deceased alive on <b>August 22, 1967</b> , and that death occurred at <b>7:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Reynaldo Orjuela-Gomez</b>		22b. DATE SIGNED <b>August 23, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>		22d. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug 24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>	23d. LOCATION (City or town) (County) (State) <b>Baltimore</b>
24. FUNERAL DIRECTOR <b>Philip Herwig &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>2024 Orleans St</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 25 1967</b>	

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REVENUE DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10817 Item #2c & d Film #1392 9/1/67 ph											
10817											
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE Md</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUMMIT CONV. HOME</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE Md. 21228</b> d. STREET ADDRESS <b>2911 Smithwood Ave</b> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
3. NAME OF DECEASED (Type or print) First <b>LEE</b> Middle <b>W.</b> Last <b>WOLF</b>						4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1967</b>					
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 22, 1883</b>		9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>26</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				11b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>				11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Wm. Wolf</b>						14. MOTHER'S MAIDEN NAME <b>Laura Wolf.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-05-1458</b>		17. INFORMANT <b>From Summit Nursing Home record</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.V.A</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Atherosclerosis</b> (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease &amp; C.H.F</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/16/1967</b> to <b>8/26/1967</b> , that (I) (we) last saw the deceased alive on <b>8/26/1967</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Adnan Sonmez M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/26/1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>ADNAN SONMEZ</b>						22d. ADDRESS <b>1011 Frederick Road</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/28/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Howard Co, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>E &amp; Mac Nabbe</b>						ADDRESS <b>301 Frederick Rd Balt 28 Md</b>		25a. REC'D BY REGISTRAR <b>AUG 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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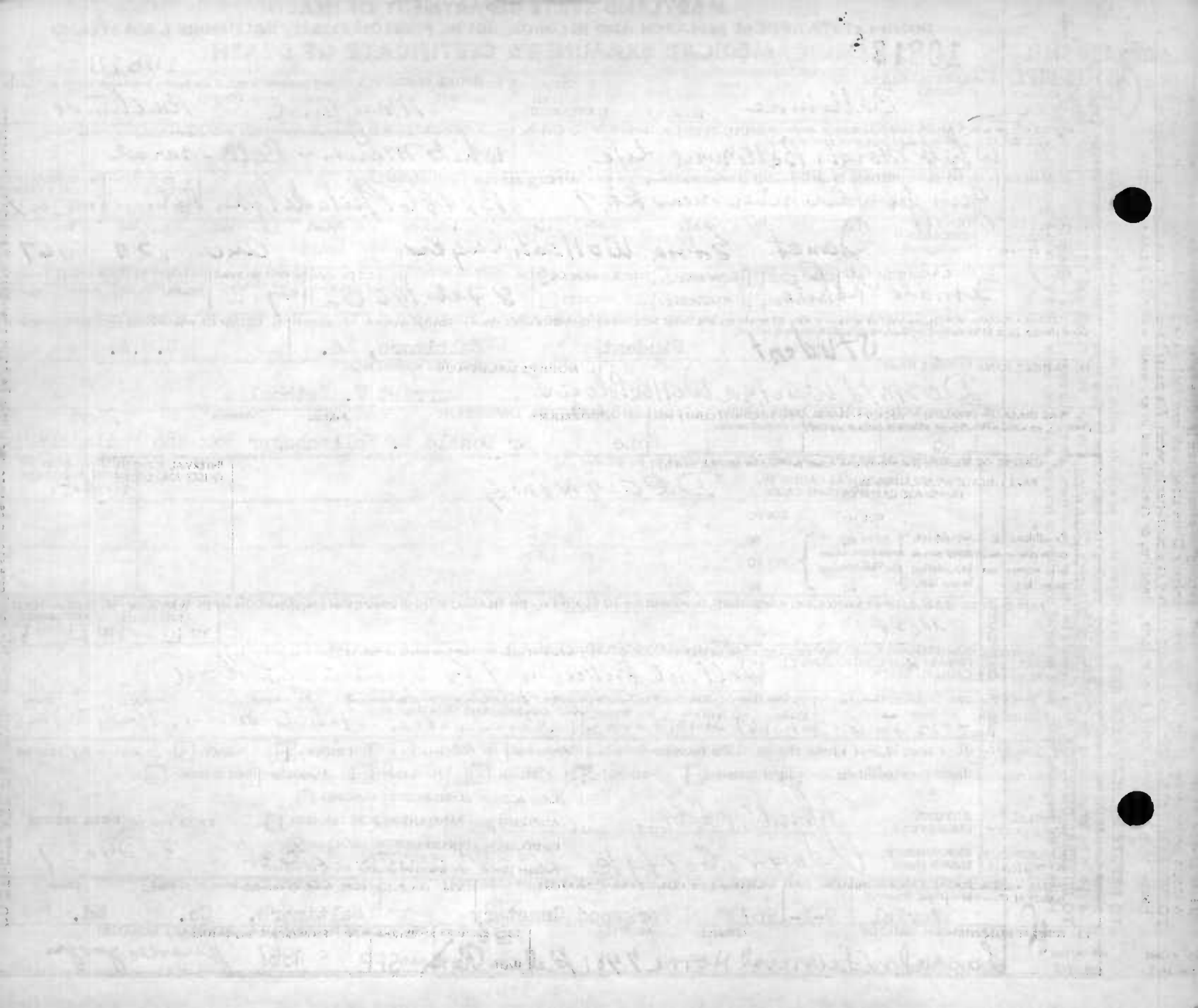
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FOR STATE  
HEALTH DEPT.  
2  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary to execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
10818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					10818									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh Baltimore life</u>			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh - Balto - rural</u> 03.1			d. STREET ADDRESS <u>Bx 486 Philadelphia Del</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>gun powder river near Rt 7</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Janet Edna Wollschlager</u>					4. DATE OF DEATH Month Day Year <u>Aug 29 1967</u>									
5. SEX <u>Female</u>		a. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		b. DATE OF BIRTH <u>8 Feb 1960</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>7</u>						
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Donald Walter Wollschlager</u>					14. MOTHER'S MAIDEN NAME <u>Harriet V. Bethouille</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address Road <u>Mr Donald W. Wollshlager Box 486 Philadelphia</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>DROWNING</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u>						
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>Fell into tributary of Gunpowder at flood</u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>4:12</u> p.m. <u>8-27 1967</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River waters</u>			20f. (City or town) (County) (State) <u>White Marsh Balto Co Md</u>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>John C. Hyle</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8-29-67</u>									
					Address (Street, city, town, or county) <u>7527 Belair Rd Balto 36</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>9-1-1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u>						
23. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7481 Belair Rd</u>					24a. REC'D BY REGISTRAR <u>SEP 5 1967</u>					24b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
10819									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Baltimore Medical Center</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>108 West 39th St. 10</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Wheeler Wrightson</b>					4. DATE OF DEATH Month Day Year <b>8 4 1967</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>Cau</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Sept. 26, 1897</b>				
9. AGE (In years last birthday) <b>69 yrs.</b>					IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chairman of Board</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Provident Savs. Bk.</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Rev. James O. Wrightson</b>					14. MOTHER'S MAIDEN NAME <b>Annie Fisher</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes World War I</b>					16. SOCIAL SECURITY NO.				
17. INFORMANT <b>Mrs. Charlotte B. Wrightson</b>					Address <b>same address</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pyelonephritis</b> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic hypertensive cardiovascular disease</b>									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>7/23</b> , 19 <b>67</b> , to <b>8/4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8/4</b> , 19 <b>67</b> , and that death occurred at <b>12:45</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>John E. Adams</b> p.m.									
22b. DATE SIGNED <b>8/5/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>John E. Adams, M.D.</b>									
22d. ADDRESS <b>6701 N. Charles Street</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
23b. DATE THEREOF <b>8/7/67</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>									
23d. LOCATION (City, town or county) (State) <b>Woodlawn, Md.</b>									
24. FUNERAL DIRECTOR <b>Wm. F. Fickner &amp; Sons</b>									
25a. REC'D BY REGISTRAR <b>Wm. F. Fickner</b>									
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									
DATE <b>AUG 8 1967</b>									

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Harvard

Belmont

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10820

CERTIFICATE OF DEATH

10820

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>1727 E. Lombard Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BILL YABLECKI</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 11 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/15/93</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIN PLATE WORKER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FELIX YABLECKI</b>		14. MOTHER'S MAIDEN NAME <b>NAME UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>213 09 07 96</b>	
17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA WITH ABDOMINAL METASTASES</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE WITH CHRONIC ATRIAL FIBRILLATION.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>5/29/67</b> , 19__ to <b>8/11/67</b> , 19__, that (X) (we) last saw the deceased alive on <b>8/11/67</b> , 19__, and that death occurred at <b>6:10A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>John D. Talbert</i>		22b. DATE SIGNED <b>8/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		22d. ADDRESS <b>VAH FT HOWARD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>AUG 14 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>
24. FUNERAL DIRECTOR		25. REC'D BY REGISTRAR <b>Aug 15 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

DIPPEL BROTHERS FUNERAL HOME  
LOMBARD & ANN STREETS, BALTIMORE, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>3 YRS 12 DA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Forest Haven Nursing Home Ingleside Ave</b>		d. STREET ADDRESS <b>1809 Lancaster Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Yanka</b> Last <b>Yanka</b>		4. DATE OF DEATH <b>August 27, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 15 1881</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Yanka</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-10-2186</b>	
17. INFORMANT <b>Eva Grochowina</b>		Address <b>1809 Lancaster St Balto. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>ARTERIO-SCLEROTIC DISEASE OF CORONARY ARTERIES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MISSIONS &amp; PULMONARY EMBOLISM (acute)</b> DUE TO <b>MISSIONS &amp; PULMONARY EMBOLISM (acute)</b> (b) <b>MISSIONS &amp; PULMONARY EMBOLISM (acute)</b> (c) <b>MISSIONS &amp; PULMONARY EMBOLISM (acute)</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/15, 1964</b> to <b>8/27, 1967</b> that (I) (we) last saw the deceased alive on <b>8/27, 1967</b> , and that death occurred at <b>7:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Shaw</b>		22b. DATE SIGNED <b>8/28/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John H. Shaw M.D.</b>		22d. ADDRESS <b>5800 Edmondson Ave. Balto. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>AUG 30 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>GERMAN HILL RD BALTO MD</b>
24. FUNERAL DIRECTOR <b>Dippel Bro's inc. 1800 E. Lombard St. Balto Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

10821

DEPARTMENT OF TRANSPORTATION

Alabama

Mobile

Forwarded by express to the following address:

Mobile

Alabama

Mobile

Alabama

Alabama

Mobile

Mobile

Mobile

Mobile, Alabama

Mobile, Alabama

Mobile

Mobile

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Mobile

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Mobile

10822

## CERTIFICATE OF DEATH

10822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GARRISON</b>		c. LENGTH OF STAY IN lb <b>24 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FOXLEIGH NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ETA BLANCHE YOUNG</b>		4. DATE OF DEATH <b>8 29 19 67</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 26 1882</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CARROLL CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEANDER GLADHILL</b>		14. MOTHER'S MAIDEN NAME <b>BELLE FORREST</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>CHARLES R. YOUNG</b>		Address <b>176 W. Main St. WESTMINSTER, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1200 Arteriosclerotic Heart Disease</b> IMMEDIATE CAUSE (a) <b>1200</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-5</b> , 19 <b>67</b> , to <b>8-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>8-28</b> , 19 <b>67</b> , and that death occurred at <b>3:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Miller</b> M.D.		22b. DATE SIGNED <b>8/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>David J. Miller</b>		22d. ADDRESS <b>Lisian Rd. Owingsville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Krinders Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rural, Westminster, Md</b>
24. FUNERAL DIRECTOR <b>J. S. Myers Jr., Westminster, Md.</b>		25a. SIGNED BY REGISTRAR <b>SEP 1 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10232

DATE

10/1/57

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10/1/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10823

## CERTIFICATE OF DEATH

10823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>_____</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>_____</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Catonsville House in the Pines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ira M Younger</u>		4. DATE OF DEATH Month Day Year <u>August 7 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1896</u>
9. AGE (In years last birthday) yrs. <u>71</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weather Stripper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Chestertown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Issac Medford Younger</u>		14. MOTHER'S MAIDEN NAME <u>SIDNEY Reed</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-4039A</u>	
17. INFORMANT <u>MRS. BETTY FOLDERAUER</u>		Address <u>21213 4103 SHANNON DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>1030</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>67</u> , to <u>Aug. 7</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>Aug. 5</u> , 19 <u>67</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert K. Gallagher</u>		DATE SIGNED <u>8/7/67</u>	
PHYSICIAN'S NAME (Type) <u>Robert K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>Baltimore, 21228 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 10, 1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Carmel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dippel Brothers Inc. 1800 E. Lombard St. 21231</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
10824			
CERTIFICATE OF DEATH			
10824			
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7yrlmthl4dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4101 Roland Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Ruth</b>		4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1894</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>15</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Art</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Christian Youse</b>		14. MOTHER'S MAIDEN NAME <b>Louise Ebert</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-54-3482T</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>July 1, 1960</b> to <b>Aug. 15, 1967</b> , that <b>1</b> (we) last saw the deceased alive on <b>Aug. 15, 1967</b> , and that death occurred at <b>4:05</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Anthony J. Young, M.D.</b>		22b. DATE SIGNED <b>8-16-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>		22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 18, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Townson</b>		25a. REC'D BY REGISTRAR <b>AUG 18 1967</b>	
ADDRESS <b>1050 York Road Towson, Maryland 21204</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>	

10884

RECEIVED

TO THE DIRECTOR OF THE BUREAU OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or official communication.]

10825

## CERTIFICATE OF DEATH

10825

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>333 Harlem Lane,</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u>		d. STREET ADDRESS <u>3213 Howard Park Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES William ZIMMERMAN</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-10-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk U.S. District Court</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>93</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bernhardt T.W. Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Robert Zimmermann</u>		Address <u>3213 Howard Pk. Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinson's Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>October</u> , 19 <u>64</u> , to <u>August</u> , 19 <u>67</u> , that (I) <u>had</u> last saw the deceased alive on <u>August 23</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Millard T. Traband, Jr.</u>		22b. DATE SIGNED <u>25 Aug. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr.</u>		22d. ADDRESS <u>1811 North Rolling Road, Baltimore, Md. 21207</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-28-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u>		25a. REC'D BY REGISTRAR <u>AUG 28 1967</u>	
ADDRESS <u>-4600 Liberty Hghts. Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

